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ABSTRACT

The issues of this quarterly publication and year end supplement contain professional articles on topics that concern at risk youth and emphasize preventive measures. Number 1 highlights the importance of mentoring programs for at-risk youth. Discussions on mentoring for special groups such as gifted adolescents and lesbian and gay youth are included. Number 2 focuses on adolescent grief and bereavement. It focuses on some of the interventions and strategies one may use both in the school and community setting to assist youth who are in mourning and dealing with grief issues. Number 3 looks at alcohol use among adolescents and the prevention models that address it. Number 4 examines juvenile sex offenders and presents prevention-based material for mental health professionals. The annual supplement is a resource issue focusing on the topics of depression, alcohol, eating disorders, homeless youth, and lesbian, gay, and bisexual youth. It also contains book reviews and numerous web resources and publication guides. A cumulative topic index is included that reflects the past 9 years of the publication. (GCP)

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The Prevention Researcher, 2002

Steven Ungerleider, Editor

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Mentoring Programs for At-Risk Youth

by Gregory Clinton, M.Ed.

In an age of fast-paced living and near constant overload of both information and obligation, adults often find it hard to set their tasks aside long enough to spend time with young people. Consequently, youth today often feel a sense of alienation toward the rest of society that may be expressed in a variety of destructive ways. Moreover, for youth who grow up with risk factors such as poverty, violence in the home, substance abuse in the family, and other hardships, this alienation may be magnified and can lead to low school achievement, antisocial behaviors, gang affiliation, violence, school dropout, and other such manifestations.

Many communities have set up mentoring programs in response to these problems. This article will introduce the concept of mentoring and its relationship to resiliency. The author is indebted to a number of helpful sources for this material, and would like to invite you to view them at www.TPRonline.org.

Mentoring and Resiliency

Mentoring is a relationship between two individuals of different ages that is formed to support the younger person through some aspect of development over a period of time. The mentoring phenomenon is understood to be a nurturing relationship outside of normal family ties.

While many interacting factors can put a young person at risk, researchers agree that caring adults who are available to a youth over time can positively influence the direction of that youth's development. The needs that mentoring addresses and the benefits it provides can best be described in terms of varying degrees of resilience in a youth's life. Some people seem to have an inner resilience that allows them to overcome adversities beyond what might be expected of them. The extent to which this resilience is innate, or how much it derives from other factors, is not clear. However, even if resilience is largely innate, it is not unchangeable. Multiple risk factors sustained over time appear to wipe out what resilience a youth may have. Fortunately, the converse is also true: protective influences can increase a youth's resilience.

Considered in this light, resilience becomes a major focus for any effort to serve at-risk youth. Youth who are sufficiently resilient can often survive and even thrive despite adverse personal, familial, or social conditions. An attempt to trace the sources of this ability to overcome adversity often leads to relationships with significant adults outside of the immediate family. Some researchers suggest that these mentoring relationships also address the issue of "social capital"—the social and economic potential embodied in human relations. Mentorship programs can help restore some of this capital to youth who have been denied a normal share of it because of one or more risk factors in their lives.

Therefore, many school systems and communities around the nation have been turning to volunteer mentoring programs to foster resilience in at-risk youth. There is a popular appeal in mentoring programs, partly due to recent social trends such as community renewal movements, recognition by businesses of the unpreparedness of American youth for the workplace, and volunteerism encouraged by federal policy initiatives (e.g., the National Mentoring Center, the Points of Lights Foundation, Americorps). Mentoring is seen as an inexpensive but meaningful and legitimate endeavor that most any community can undertake. However, communities and schools that want to establish mentoring programs must bear in mind that those very factors creating the need for mentors are the same factors that will be working against anyone looking for long-term volunteers: adults are often too busy to spend time with young people. In order to accomplish its goals, a mentoring program must be prepared to swim upstream.

Caring adults who are available to a youth over time can positively influence the direction of that youth's development.

The Motions of Mentoring

Practitioners considering mentorship programs will do well to consider what it is that happens between a youth and an older companion that accomplishes the "magic" of mentoring. The process of mentoring may be regarded as occurring in two domains: in the interaction of the mentor and the youth, and in the mind of the youth responding psychologically to the mentor and the experience. As the youth begins to "feel cared about," an observable rapport develops that facilitates the transfer of knowledge or skills to the youth. In turn, this strengthens the internal response of the youth. If this process is sustained (a big "if"), then a meaningful difference can be made in the life of the youth.

However, mentoring doesn't "just happen"; there must be some joint activity. Further, the activity may or may not relate to a specific skill being taught. Coaching in vocational or academic

(Continued on Page 3)

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From the Editor's PC

Dear Colleagues:

Mental health professionals often tend to overlook the obvious; that is, we try to diagnose a problem, do an intervention, solve the problem, and move forward. However, sometimes for lasting effects, the "intervention" should be a "prevention." Mentoring is one such prevention. It is not only cost-effective and available in every community, but it has powerful impacts and outcomes.

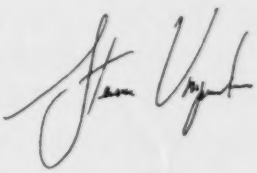
We are excited about this current issue on adult-to-youth mentoring. It includes resources that we think will open new doors in the prevention community. We would like to thank our excellent authors, who are some of the most prominent people in the mentoring field, for sharing their research with us.

Authors for this issue include: Gregory Clinton, M.Ed., a development specialist for Teacher's Workshop in Bishop, Georgia; Jean Baldwin Grossman, Ph.D., a lecturer at Princeton in the Woodrow Wilson School of Public Affairs and Senior Vice President for Research at Public/Private Ventures; and Amy Johnson, Ph.D., senior researcher at Mathematica Policy Research, Inc.

Also joining us are Kerry M.A. Casey, M.A., a guidance counselor from New Brunswick, Canada; Bruce Shore, Ph.D., professor of education at McGill University; and Margaret Waller, Ph.D., associate professor of social work at Arizona State University.

This is a terrific issue, full of useful information about mentoring systems. I hope you will read it, share it with colleagues, and get it into the hands of the professionals who can use these ideas and implementation strategies.

We wish you a very productive spring.



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skills, for example, can help to provide a framework for the relationship, but more mundane activities that arise out of everyday life can also provide many opportunities for the youth to learn from the relationship.

Bonnie Benard, Prevention Specialist for the Western Regional Center for Drug-Free Schools and Communities, has outlined five characteristics that make up an effective mentoring relationship. The first of these is *personalized attention and care.* More than simply a one-on-one encounter, mentoring implies a level of personal interest and concern on the part of the mentor that invites trust and self-disclosure from the student. Unlike standard classroom teaching, in which all learners must pursue the same learning agenda at more or less the same pace (despite differences in interests, abilities, or personal problems), the mentoring model is based on having these very interests and challenges be the core of the adult-youth relationship. The youth must be able to perceive, through the actions of the mentor, an interest in his or her own concerns and problems.

Broadening the youth's horizons is a big part of what mentoring seeks to accomplish.

Second, effective mentoring provides *access to resources.* Broadening the youth's horizons is a big part of what mentoring seeks to accomplish. This means not only new awareness of the world around them but also awareness of real options for both fun and fulfillment. Many mentors, for example, serve as tutors, coaches in job interviewing, companions on college campus visits, or any number of other helping roles which may open up doors of opportunity. Along with the awareness that someone cares, a mentor can help foster a "coming to terms" with life's options in such a way that the youth becomes more willing to coexist with others positively.

Third, effective mentoring brings *positive/high expectations* on the part of the mentor toward the student. The mentor's essential message to the youth is that he or she can be successful, with the goal that the youth internalize this message. At-risk youth have a particularly acute need for relationships that challenge them with high expectations. These students have suffered not only from a lessening of normal social supports, but also from low expectations conveyed to them from their earliest days in school. This has tended to lead, in turn, to avoidance of intellectual challenges. A good mentor can help to restore the high expectations and intellectual challenges that, for one reason or another, have been missing in a youth's life.

Fourth, mentoring does not really happen unless the youth becomes more than a passive recipient in the relationship. *Reciprocity and youth participation* provide the initial feedback which suggests that the relationship is accomplishing something. Mentors can encourage reciprocity by engaging the youth in joint problem solving activities and ongoing decision making. By communicating to the youth that their opinion is taken seriously and acted upon, both their problem solving skills and their sense of autonomy are enhanced. These are the very traits that characterize a resilient youth. Further reciprocity can be promoted by involving the mentored youth themselves in tutoring or mentoring a younger student.

Finally, mentoring programs do not survive without *commitment.* The mentor's commitment of his or her time, along with faithfulness to appointments, is crucial. However, the mentee must also commit to the agreed-upon arrangement, with its appointment times and its duration over time. One of the characteristics of students who are more likely to benefit from mentoring is the ability to show up for appointments with a reasonable level of predictability. For mentoring programs that meet during school hours, student faithfulness to mentor appointments is closely tied to school attendance and therefore somewhat easier to predict.

Researchers point out that in the "real world," mentoring relationships are usually measured in years. Most planned programs, on the other hand, have mentors commit to anywhere from six weeks to one year, with frequency ranging from one hour per week to daily contact. Planned programs clearly can make a difference; however, whether an individual mentoring relationship has an impact obviously depends to a large degree on the number of contact hours.

Beyond these basic characteristics of good mentoring, a number of techniques are often used to help the youth achieve success in a joint activity. These may include modeling the activity, providing feedback, using task structuring to break a task into component parts, and having the youth explain the activity. Suffice it to say the mentor is there to challenge the student toward learning beneficial skills or new perspectives and to give every possible manner of support along the way. -x-

Gregory Clinton, M.Ed., is a staff development specialist for Teacher's Workshop of Bishop, Georgia. In addition to co-editing the book *Violence Prevention and Reduction in Schools* (ProEd, 1999), he is the author or co-author of more than a dozen articles and book chapters on various educational topics. He holds a master's degree in Special Education from the University of Georgia.

This article is condensed from G. Clinton and W. Miles. (1999). Mentoring Programs: Fostering Resilience in At-Risk Kids. In W.N. Bender, G. Clinton, and R.L. Bender (Eds.). *Violence Prevention and Reduction in Schools.* ProEd: Austin, Texas. It has been condensed and reprinted with permission from the publisher, ProEd.

Case Study
Lakrisha & Denise

Lakrisha was a little girl in a high-risk situation — one that would expose her to violence and have her living in 10 different places in 6 years. Denise was resolved to be a mentor. The two connected through the local YWCA. "In the beginning, we'd just go to the zoo, bake cookies — nothing really big," Denise said. "Lakrisha helped me volunteer at other things, like packing food baskets for Thanksgiving." Their relationship was tested numerous times. For example, when Lakrisha was sent to live with out-of-town relatives. To keep their friendship afloat, they wrote letters and Lakrisha used the calling card Denise provided. Their tenacity paid off. Today, they are close and have faced many issues in conversations. "We've talked about how to deal with anger and problems. She has a couple of friends who've gotten pregnant; we've talked about that, too" says Denise. Lakrisha added, "It's been great because she's real nice, and I can talk with her about anything."

This story was excerpted from the *How to Be a Great Mentor Guide,* developed by The National Mentoring Partnership with *Newsweek* Magazine and Kaplan Educational Services.

Setting Up a School-Based Mentoring Program

by Gregory Clinton, M.Ed.

In his work in the area of mentoring, Jay Smink, director of the National Dropout Prevention Center, has proposed a set of twelve steps for getting a new mentoring program started. A modified version of these steps provides a framework for the following discussion of the essentials for establishing your program.

1. Establish the Need. When considering mentoring as a possible component of your school's extended services to students, certain questions must be answered to ascertain or clarify the need in your school. For example, what problems need to be addressed? Which students will participate? What local sources are available for finding mentors? How will the program be led and coordinated? Because needs and available resources vary considerably at the local level, no one model can be presented as an optimal approach to mentoring.

2. Secure Commitment of Building and District Leadership. The level of commitment and energy of the program leader will be a big determining factor of the success or failure of the endeavor. However, even quality leadership may not keep a program going if it does not also become a part of the fabric of existing structures in the school or community. Mentoring programs that survive for the long term tend to be those that are institutionalized within a larger organization or integrated into a battery of youth services. Being embedded in the larger framework of services increases the likelihood of regular funding and, as a result, longer-term paid staff.

Getting the school administration or the district "on board" is therefore essential. Without a firm commitment from school building leadership, mentoring appointments will tend to be seen as competing with, rather than complementing, other services or programs in the school's schedule.

3. Identify and Select Program Staff. A steering committee or advisory board, comprised of school staff, parents, business representatives, community leaders, and perhaps students, may be set up as the mentoring program's governing body. These persons represent the stakeholders in the project and their input, particularly for district wide programs, is essential. However, within the school, one coordinator should be assigned to oversee the day-to-day progress of the program and to be available to participants whenever problems occur. Again, this position should be strengthened by paying the coordinator a monthly stipend and by making monies available for expenses. This not only helps to meet program needs, but also promotes longer tenure in the position, which increases program stability. District-wide programs, likewise, should be set up with paid district-level staff to work with school coordinators.

4. Establish Program Goals and Objectives. Well-articulated program goals which center on building youth competence provide benefits on two essential levels. First, a mentoring effort that is driven by clear goals will administratively run more smoothly. Clear goals help keep administrative decision-making in focus, thereby avoiding the decline in morale and effectiveness that can come with "mission drift."

Second, clear and achievable goals for the program translate into clear and achievable goals for the mentoring pairs. These may be, for example, development of academic or career skills that will help youths successfully negotiate the transitions they are facing. Mentor and student are thus given a structure, a common task at hand, that gives the relationship "something to grow out of." A common interest is, indeed, the stuff that friendships are made of. A positive interpersonal relationship is more likely to grow out of a joint task or goal than out of a focus on building a relationship. Ideally, the task at hand will be one that lends itself well to this dual purpose of developing both the relationship itself and the competencies of the youth.

Each program goal, in turn, must be translated into measurable objectives. Specific, concrete objectives will provide the program with a way to assess progress toward reaching its goals. Without well-written objectives as guideposts, program coordinators may lack direction and have no clear means of reporting program accomplishments.

Mentoring pairs need to have an activity they can pursue together, to provide a basis for their relationship to grow.

Several objectives should typically be listed for each goal. Each objective should include a time frame. Some objectives should be designed to be met early in the school year, with others in the middle, and some at year end. Example objectives might include:

- ✔ By the October 1 launch date, all mentor-student pairs will be assigned.
- ✔ By the ninth week, eight out of ten students will have mastered the first vocational skill area assigned (e.g., job application forms);
- ✔ By the end of year one, incidents of aggressive or violent behavior involving students in the program will have decreased by 40%.

Bear in mind that some of the benefits we seek may be rather intangible—we want students to find more meaning in life, to become more resilient, to begin recognizing a wider set of solutions to problems. These will never be measured as accurately as we would like, but questionnaires and/or interviews can be used to gather evidence of improvement, and results on these can be incorporated into program objectives. For example:

- ✔ By the end of year two, 85% of student participants will report that they prefer a non-violent response to threatening situations.

5. Prescribe Activities and Procedures. Mentoring pairs need to have an activity they can pursue together, to provide a basis for their relationship to grow. This activity should be determined

by the goals of the program. If the primary goal is academic improvement, some form of tutoring is most appropriate. If reduction of violence or aggressive behavior is the goal, common interest in a particular hobby may provide a non-threatening framework that will allow the mentor to engage the youth in probing conversations about choices and values. If the relationship "takes hold," hopefully the weight of the mentor's influence can make a difference.

Procedures for mentors also need to be clarified. You will need to determine the kind of relationship you anticipate between mentoring pairs and develop guidelines for mentors. Questions such as when, where, and how long to meet, how much flexibility there is in meeting times, assigned activities, family contact policy, and what is expected by students should be addressed clearly for mentors during early training. A mentor handbook of some kind should be created, and a calendar of scheduled activities should be provided as well.

In order for mentoring to be effective, both mentors and students must be adequately prepared for the experience.

6. Identify Students. Students are generally voluntary participants in the mentoring program. They may be referred by teachers, their parents, school guidance counselors, social workers, or the court system. The type of student to be served should be determined carefully by the steering committee and incorporated into the stated program goals. The primary issue in selection of students is whether mentoring is appropriate for truly disadvantaged or troubled youth or whether mentoring is best suited for youth in the middle, who could overcome their life circumstances with a little extra support. If you want to serve the truly disadvantaged, you must prepare for long term, intensive mentoring and be ready for frustrations along the way. Research indicates that successful mentoring programs generally have been those serving kids whose academic or behavioral problems are not too severe and whose cooperation with the program is not difficult to obtain. This is a reasonable observation because most programs depend on adult volunteers who are not trained social workers or behavioral specialists.

7. Promote Program and Recruit Mentors. Selection of adults for participation in a mentorship program must be done judiciously. It is not an easy task. Though simply finding enough volunteers can be quite a challenge, screening of potential mentors is needed to assure that unsuitable applicants are eliminated during the recruitment process. Two critical concerns involve the seriousness of applicants' time commitment and whether their expectations are realistic. Applicants need to be informed about the hard realities of mentoring from the beginning so that only the truly committed ones will choose to continue with the program. Other issues will also need to be considered. For example, persons who have a record of predatory behavior toward children should not be provided with the kind of ready access to individual youth that mentoring affords. Ideas on where to look for mentors are presented in Figure 1.

An application form must be created to give to potential volunteers. This application form will serve as the front end of the screening process and should include a release form authorizing receipt of criminal record information, on an annual basis, from any law enforcement agency.

FIGURE 1

Where should you look for mentors?

There may be more potential mentors out there than you think. Sources to consider either for volunteers or for referrals:

- Major Businesses
- Co-workers
- Steering Committee Members
- Other School Volunteer Programs
- Service Organizations and Clubs
- Parents of Youth in Mentoring Programs
- Post Secondary Educational Institutions
- Media (newspaper, TV, radio, etc.) Announcement
- Chambers of Commerce
- Individual Businesses
- Community Education Programs
- Volunteer Referral Services
- Local Religious and Cultural Organizations

Adapted from Reilly, J.M. (1992). *Mentorship: The Essential Guide for Schools and Business.* Dayton, OH: Ohio Psychology Press.

The remainder of the screening process occurs during the volunteer training. This will orient the volunteers to the realities of mentoring and the nature of the commitment desired. As you move through the recruitment and training period, usually about six weeks in length, begin meeting with volunteers individually to either confirm their enrollment or to explain why you feel the job of mentoring may not be a good fit for them.

8. Train Mentors and Students. In order for mentoring to be effective, both mentors and students must be adequately prepared for the experience. Mentors need to understand the nature of the mentoring relationship itself, e.g., "how close" it is expected to be or not be, what involvement with the youth's parents/home life is anticipated, what costs are involved, and what happens if the relationship doesn't develop as expected. Mentors need to hear descriptions of the experiences of veteran mentors as well as comparisons of communication styles between adults and youth. Additionally, program leaders can both assist new mentors greatly and further the goals of their program by acquainting mentors with the wider resources and services available to the youth, such as career information offered by the school guidance office, or community youth recreation programs, or simply the variety of learning opportunities at the local library. A tour of the school, including meeting areas for mentoring, may also be helpful; but it may also be desirable later for student participants to give mentors their own private tours of the building. Other training tips are presented in Figure 2.

Mentors not only need training, they also need ongoing support. Researchers emphasize the importance of supporting mentors and warn of the consequences of not doing so. Mentors need to be able to compare notes with each other and hear ideas about approaches and activities to try. They need to be reassured that program leaders are near, should problems arise.

FIGURE 2

Tips for Training

Volunteers should be required to attend two or more training sessions designed to acquaint them with the realities of what they are volunteering to do. Besides receiving a mentor handbook or packet, we offer the following suggestions.

- The training site should be pleasant, conducive to learning, and centrally located; refreshments should be provided.
- The presentations should be positive and convey enthusiasm. They should emphasize the rewards without glossing over the possibility of problems.
- Consider bringing experienced mentors together in a "mentor panel" to share their experiences with the trainees and stimulate the discussion.
- Volunteers should be organized into small working groups of about five persons each, including a trainer in each group, to facilitate maximum participation of trainees.
- To keep the program interesting, trainers should not lecture at length but should use a variety of learning techniques such as role playing, slides and films, and training manuals.
- Training sessions should help the mentors enhance their existing skills while learning new ones.
- During practice sessions, trainees should receive feedback on how they are doing.
- At the end of the sessions, mentors should complete a course evaluation form.

Adapted from One on One Foundation (1991). *One on One: A Guide for Establishing Mentor Programs.* Washington, D.C.: U.S. Department of Education.

Support meetings can be conducted initially by program leaders; some of these meetings may in time be turned over to experienced mentors. Also, mentors need to be recognized for their efforts. A public recognition event should be scheduled. The acknowledgment of the mentors' contribution provided by this kind of event should be supplemented throughout the year by notes or tokens of appreciation from teachers, administrators, and parents.

Youth also need an orientation to the mentoring concept and experience. They need to know what to expect from the mentoring relationship, including many of the same issues that must be covered with mentors, such as mentor involvement with parents (if any), where and when to meet, and whether the mentor will be expected to spend any money on treats or other items. Students will also need to understand the nature of their part of the commitment to meet together, in order to get the most out of the program.

Initial student training can be generally accomplished in a single orientation session, although you may wish to conduct follow-up meetings from time to time. Youth who have been involved in the program for the first year or more may subsequently be asked to participate in planning decisions for the following year. Figure 3 includes several additional suggestions for student orientation.

9. Match Mentors and Students. Finding a good match between mentor and student should be a major concern for program coordinators. Mentoring relationships that do not "gel," and result in withdrawal by the youth or mentor (or both), do damage to the morale of both participants. Youth who have become candidates for mentoring are often very acquainted with being let down by adults, and do not need yet another disappointment. Adult volunteers, on the other hand, can become jaded toward problem youth and be turned off from future participation as mentors.

FIGURE 3

Student Orientation

Student orientation for mentorship programs should cover:

- Program purpose and reasons the students should want to participate.
- The potential benefits of participation, including making a friend, improving in a subject, eventually gaining worthwhile employment.
- The limits of a mentor relationship—students need to understand that the mentors cannot do everything for them, nor can they be surrogate parents.
- The student's part in making the program a success, including behaving courteously, keeping appointments, and showing respect for mentors.

Adapted from One on One Foundation (1991). *One on One: A Guide for Establishing Mentor Programs.* Washington, D.C.: U.S. Department of Education.

The task of matching mentors and youth involves two primary issues: the degree of choice afforded to participants and the degree of similarity between mentor and student in terms of race/ethnic background, gender, and class. There is no clear data about whether giving participants more opportunity to choose their partner makes a difference in terms of outcomes, though most programs include this feature. Most programs use questionnaires or profiles, completed by both mentors and students (or by mentors and students' teachers), as a basis for assigning pairs. Some programs use social events to allow the pool of youth and mentors to become acquainted, and then ask each individual to list persons they would like to be paired with. In any case, the matching process should be flexible enough to allow a change of partners if a pair does not work out.

Whether to match mentor and student by same race/same sex should depend first on program goals. Some programs, for example, are set up specifically to provide black male role models for inner city black youth. Most school-based programs, on the other hand, are set up to serve any youth that can especially benefit from a mentor. Moreover, these programs often will not have an even match of characteristics between available mentors and qualifying students.

The literature suggests that, in general, program coordinators need only avoid what might be called "excessive" social or socioeconomic distance between mentor and student. Cross-race or even cross-gender pairs may not always be the ideal, but these mentors can still bond with and be quite beneficial to the

youth. Bear in mind that as a means of expanding the horizons of the youth some socioeconomic difference is desirable. While mentors from outside the student's day-to-day world will not readily comprehend the realities of that world, this does not prevent them from being good mentors. It is the caring attitude of the adult that matters most.

10. Monitor the Mentoring Process. After each encounter between mentor and student, a report sheet should be completed and turned in to the program coordinator. These reports become the primary means of tracking the progress of each relationship and of the program as a whole. The information provided by report sheets (e.g., the activity they were engaged in, issues of concern, etc.) will be supplemented by feedback from mentors shared during monthly meetings. Questionnaires or phone calls from program leaders may also be used for this purpose. Program leaders must review this information on a continual basis in order to address problems as they occur and to make reassignments if necessary. They must also be prepared to make other services, such as counselors or social service agencies, available to the youth as needed.

Mentoring can fortify the youth's inner resilience by supplying a needed protective influence.

11. Evaluate Ongoing and Terminated Cases. An evaluation questionnaire, along with monitoring data, will help to determine the quality of the mentoring relationship experience. It will allow program leaders to determine whether program goals and objectives are being reached. Separate forms should be developed for adults and for students, and may be administered at the end of each year or after an individual relationship is discontinued.

12. Revise Program and Repeat Steps. At the end of each school year, the monitoring and evaluation data permit an evaluation of actual experiences as compared with the program's stated goals and objectives. This information, along with suggested revisions, should be shared with the steering committee or advisory board. Revisions will generally affect program procedures, but may also take the form of adjustments in the program's goals and objectives. These revisions can be incorporated into the program for the subsequent year.

Conclusion

Although planned mentoring programs are a modest intervention, they can nonetheless serve as a key component in your school's overall approach to serving at-risk kids. As part of a continuum of support services, mentoring, if maintained in a youth's life, can fortify the youth's inner resilience by supplying a needed protective influence. As mentoring becomes more recognized, not only as a worthwhile endeavor, but also as a feasible option in schools and communities, it is to be hoped that the value of spending time with youth might gain a higher profile in the public eye. However, planned mentoring programs still often lack depth and stability. The more these programs can be interwoven with other services and stabilized by regular funding, the better the chance that they will survive and benefit students for the long term.

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Mentoring: What Is It?

Definitions of mentoring vary widely, as do individual youth mentoring programs and the type of relationships they promote. Broadly defined, mentoring is a one-to-one relationship between a caring adult and a youth who needs support. Unlike natural mentoring relationships which may develop independently between students and teachers, relatives, or coaches, planned mentoring relationships are those in which a young person is matched with a mentor through a structured program with specific objectives and goals.

While they may overlap, mentoring programs can typically be broken down into three general types:

- Educational or academic mentoring focuses on improving students' overall academic achievement. While these programs generally have specific school-related goals, mentors do not concentrate only on tutoring or doing homework with their mentees. Instead, some academic mentoring programs ask that mentors simply spend time encouraging, talking to, and becoming friends with their mentees, hoping to boost academic performance indirectly by improving students' attitudes about school, raising personal goals, giving them incentives to attend regularly, etc.
- Career mentoring helps youth develop the skills needed to enter or continue on a career path. Career mentoring programs often pair students with adults who work in the students' general field of interest, providing students with a role model who can familiarize them with the world of work and offer guidance and support as they prepare to make the transition from school to work or higher education.
- Personal development mentoring supports youth during times of personal or social stress and provides guidance for decision-making. While these programs may foster improved academic performance, they focus primarily on improving student self-esteem, behavior, and decision making ability; reducing high-risk behaviors such as gang involvement, premature sexual activity, criminal activity, and drug and alcohol abuse; and introducing students to social, cultural, and recreational activities they may not previously have experienced.

From C. Brewster & J. Fager. (1998). *Student Mentoring. By Request series.* Portland, Oregon: Northwest Regional Educational Lab. Used with permission. The full report is available online at www.nwrel.org.

Assessing the Effectiveness of Mentoring Programs

By Jean Baldwin Grossman, Ph.D., and Amy Johnson, Ph.D.

In a world of limited resources, we increasingly seek programs that provide the most "bang for the buck." Even mentoring programs that rely on volunteer efforts and charitable financial support are being put to this test. Fortunately, several recent evaluations have documented that well-run mentoring programs matching a caring adult with a youth can significantly improve the youth's life. But, studies have also shown that not all mentoring programs are effective. Programs that lack sufficient infrastructure to screen and monitor volunteer efforts are unlikely to produce relationships that have many positive effects. In fact, a disappointing relationship can have an adverse effect, eroding a youth's self-esteem and trust in adults.

Determining a program's effectiveness is crucial, but conducting a rigorous evaluation is costly and takes many years. So how can a program assess its effectiveness? We believe a viable approach is to use a set of programmatic quality benchmarks and indicators of in-program effects that have been empirically linked to longer-term effects. Using data available from their two recent evaluations, this article presents a number of benchmarks and indicators we have developed for two successful mentoring programs, Big Brothers Big Sisters (BBBS) and Philadelphia Futures' Sponsor-A-Scholar (SAS).

Our approach directly links a number of programmatic quality measures to significant improvements in youth performance and presents the levels of these quality measures found in the BBBS and SAS programs. Staff from mentoring programs can use our findings as benchmarks against which to gauge their own program's relative effectiveness.

First, four points about the value and validity of using benchmarks from these two evaluations as a way to infer other program's effectiveness should be considered:

1) Though they are both mentoring programs, BBBS and SAS differ fundamentally in objectives, operations, and the size and characteristics of populations served.

2) The evaluations of each program were rigorous in design and compared respective program impacts on participant behaviors to behaviors of a matched comparison group. Though the outcome measurements differ (largely because of differences in program objectives), the variables hypothesized to affect these differing outcomes were remarkably similar.

3) Despite operational differences, the findings that emerged from these two evaluations are remarkably consistent. It is this consistency that suggests an opportunity for other mentoring programs to use these findings as benchmarks against which to measure their own effectiveness.

4) Both BBBS and SAS are well-run, carefully monitored programs with clear objectives. Without adequate infrastructure, there is no ground for assuming that any other program will be equally effective. Program operators must look closely at issues of infrastructure, including mentor selection and training, expectations for individual relationships, and the operational support provided to both the mentors and youth who participate.

This article explores three types of benchmarks that other mentoring programs could use to gauge their own effectiveness: indicators relating to target population, quality measures of individual mentor-youth relationships, and changes in outcomes. Though other programs will undoubtedly differ in important ways from the BBBS and SAS programs, we feel that the collective and consistent evidence presented here provides critical information on key variables.

The Programs

Big Brothers Big Sisters

For over 90 years, BBBS has paired unrelated adult volunteers with youth from single-parent households in an approach that is intensive in delivery and broad in scope. The volunteer and the youth agree to meet two to four times per month for at least one year, with a typical meeting lasting three to four hours. BBBS is not designed to ameliorate specific problems or reach specific goals but rather to provide a youth with an adult friend who promotes general youth development objectives. Each BBBS program has a professional staff of caseworkers who screen and train mentors and supervise each mentoring relationship. Program staff also support the match by providing guidance when problems arise in the relationship.

Well-run mentoring programs matching a caring adult with a youth can significantly improve the youth's life.

The effectiveness of BBBS for all eligible youth ages 10 to 16 who enrolled in the program at eight study sites between October 1991 and February 1993 was evaluated. Over half of the sample members were boys (62.4%) and 57.5% were members of a minority group. Over 40% of the youth lived in households that were receiving food stamps or cash public assistance, or both.

During the study's intake period, half the 1,138 applicants were randomly selected to be put at the top of the waiting list. Case managers attempted to match these youth with a Big Brother or Big Sister as soon as possible. The other youth were put on the waiting list for 18 months. The impact of BBBS was determined by comparing the outcomes for these two groups 18 months later. At that time, on average, the participants had been matched for almost 12 months.

Sponsor-A-Scholar

The primary goal of SAS is to help students from Philadelphia public high schools "make it" to college. This goal is sought through a range of support services, chief among which are the provision of long-term mentoring and financial help with college-related expenses.

SAS provides students with adult mentors for five years: from ninth grade through the first year after high school, which is to be the first year of college. Participating students must attend one of the city's public schools and be middle-achieving students. Students must also be financially disadvantaged.

Mentors commit to working toward a set of ambitious objectives; the ultimate benchmark of success of the relationship is the student's entrance into and attendance in college. Toward this goal, mentors are expected to monitor their student's academic progress, to help with the financial aid and college application processes, and to participate in program activities and events.

The evaluation of the SAS program began in 1993. All SAS students who were then high school seniors, juniors, sophomores and incoming freshmen became part of the study. A comparison group was selected by matching non-SAS students in Philadelphia high schools with program participants on the basis of race, gender, school attended and ninth-grade academic performance.

The final study sample of 434 students was more or less evenly divided between males and females. More than three-fourths of the students were black; a little under half had parents with some education beyond high school; a little over half came from families with a working mother; and a little over half were from single-parent homes. Virtually the entire sample felt they had the ability to complete college.

Benchmarks

BBBS and SAS differ in many respects, including the age of the youth served, the services provided, and how frequently the mentor and youth should meet. What BBBS and SAS share with all mentoring programs, however, is that they foster relationships between a youth and an adult. Therefore, we investigated the characteristics of the relationships' quality.

The longer a relationship lasts, the more likely a mentor will have a positive effect on a youth.

We found that the various quality measures of the relationships in the two programs were related to effects. This consistency of evidence strongly suggests that the quality measures of mentoring relationships are likely to be useful benchmarks for other mentoring programs. Because these features are empirically linked to positive participant outcomes in both evaluations, others interested in the relative effectiveness of their respective programs can use these as benchmarks against which to gauge the likely direction of the impact on their own participants' outcomes.

Relationship Characteristics

Common sense tells us that better relationships should have better effects on youth. But what measures of a relationship capture the essence of "better?" One can characterize relationships according to objective measures, such as how long they have lasted, or according to subjective measures, such as how comfortable the parties are in the relationship. The data collected in the SAS and BBBS evaluations enable us to examine the link between both objective and subjective measures and mentoring effect.

Length of the Relationship

The longer a relationship lasts, presumably the more likely a mentor will have a positive effect on a youth. Relationships of short duration probably do not give adequate time to develop the mutual trust and respect necessary for real growth to occur on the part of the youth. But how long do relationships have to be? Because the SAS program requires a five year commitment, for this analysis, we use only data from the BBBS study. Youth were divided into four groups according to the length of time they were matched with an adult. The significant effects as compared to non-mentored youth were as follows:

Students in BBBS relationships more than twelve months:

- Felt more confident about doing their school work,
- Skipped fewer school days,
- Had higher grades, and
- Were less likely to start using drugs or alcohol.

Students in BBBS relationships lasting six to twelve months:

- Skipped fewer school days.

Students in BBBS relationships lasting three to six months:

- No significant impacts.

Students in BBBS relationships lasting less than three months:

- Felt less confident about doing their school work,
- Had substantially lower sense of self-worth, but
- Had slightly higher grades.

Frequency of Contact

Just as the length of the relationship between mentor and youth is presumed to provide more opportunity for positive influence, so is more frequent contact. Simple correlations, however, do not show this. It appears, at least to some extent, that mentors who meet frequently with youth are experiencing the greatest struggles. In BBBS, where the meeting expectation is approximately once a week, students with once-a-week contact showed more positive outcomes than did students with more and less contact. Thus, frequency of meeting should probably not be used as a benchmark for mentoring programs with near once-a-week meeting requirements. On the other hand, in SAS where the meeting requirement is once a month, frequency of meetings did correlate well with academic outcomes. In SAS, students who met with their mentors most frequently (at least once a week) did significantly better on the tenth, eleventh and twelfth grade GPAs and on first-year college attendance. Students who met with their mentors at a more moderate rate of frequency (more than once a month but not as often as every week) and those who met with their mentors least often (less than once a month) experienced much less consistent effects.

The extent of telephone contact between adult and youth appears a somewhat more useful indication of whether the relationship is leading toward positive outcomes for the youth. In the BBBS evaluation, frequency of telephone contact was measured as less than once a week, once a week, and more than once a week. In the SAS program, frequency was measured as less than once a month, more than once a month but less than once a week, and once a week. Comparing mentored and non-mentored youth on three levels of phone contact the significant effects were as follows:

Students who spoke with their mentors on the telephone with the greatest frequency:

- Were more likely to feel a sense of school competency (BBBS),
- Were less likely to skip school (BBBS),
- Had higher grades (BBBS), or had a higher tenth grade and/or eleventh grade GPA (SAS),
- Were less likely to start using drugs (BBBS),
- Were more likely to be enrolled in college the first year after high school (SAS),
- Were more likely to be enrolled in college the second year after high school (SAS), and
- Had a higher rate of persistence between the first and second years of college (SAS).

Students who spoke with their mentors on the telephone with a moderate rate of frequency were:

- Less likely to skip school (BBBS),
- Less likely to start using drugs or alcohol (BBBS), and
- More likely to be enrolled in college the first year after high school (SAS).

Students who spoke with their mentors on the telephone with the least frequency:

- Were less likely to skip school (BBBS), and
- Had a higher GPA in tenth grade (SAS).

Quality of the Relationship

Both evaluations included measures designed to reflect the quality of the mentoring relationship. Using youth's own sense of pleasure or satisfaction with their mentoring relationships is a useful means of understanding the quality of the match. The impacts for those in "good" relationships were positive and consistent across the two evaluations, showing the strength of these measures as a gauge for how likely a relationship is to produce intended outcomes.

The BBBS evaluation included four measures that reflect quality of relationship: the youth's sense of disappointment in the mentor and the relationship (for example, not asking about themselves, or making fun of them); the youth's perception of whether the relationship was youth-centered (for example, activities are centered around what the youth wants to do); the youth's emotional engagement in the relationship (for example, whether the youth is happy, or feels special, ignored, or bored); and the caseworker's assessment of whether the mentor took a negative approach, pushing the youth too hard and having difficulty setting limits with the youth's family. The SAS evaluation included one measure designed to reflect the youth's sense of the quality of the relationship, based on the youth's sense of how much respect, understanding, closeness, and excitement there was in meeting. Comparing mentored and non-mentored youth on three levels of relationship quality, the significant effects were as follows:

Youth in relationships with the highest positive rating:

- Were more likely to feel a sense of competence in school (BBBS),
- Were less likely to skip school (BBBS),
- Had higher grades (BBBS),
- Were less likely to start using drugs or alcohol (BBBS),
- Had a higher tenth, eleventh, or twelfth grade GPA (SAS),
- Were more likely to be enrolled in college the first year after high school (SAS), and
- Were more likely to be enrolled in college the second year after high school (SAS).

Youth in relationships with a moderately positive rating:

- Were more likely to feel a sense of competency in school (BBBS),
- Were less likely to skip school (BBBS),
- Were less likely to start using drugs (BBBS), and
- Were more likely to be enrolled in college the first year after high school (SAS).

Youth in relationships with the least positive rating:

- Were less likely to skip school (BBBS).

Using the Benchmarks

For those interested in using these benchmarks to gauge the effectiveness of their own program, we suggest downloading our full report, *Contemporary Issues in Mentoring*, from our web site (www.ppv.org). The report includes the specific questions of each benchmark measure along with instructions on how to construct each measure using the answers given by the youth or caseworker.

Once a program collects data and the benchmarks are calculated, how should they be interpreted? Against what should the data be compared? One good comparison is with measurements taken earlier. If, over time, the benchmark levels are improving —that is, matches are lasting longer and the relationships are more satisfying—then a program can infer that it is probably having more positive effects. Another comparison that could be made is to measurements taken in other similar, but proven, mentoring programs (like BBBS or SAS) that serve similar youth. If the staff of a BBBS- or SAS-like program find that their benchmark distributions were at least as favorable as those of the BBBS or SAS, then it is reasonable to assume that the program is having similar positive effects.

Determining Program Effectiveness By Using Changes in Outcomes

These benchmarks describe the connection between participant and relationship characteristics on the one hand, and program outcomes on the other. Although benchmarks are correlated with outcome impacts, they are not measures of actual changes in participant performance. Policy makers, funders, parents and program staff are ultimately interested in changes in performance.

Perhaps the most direct way to assess a program's effect is by examining how participants change over time. Though this strategy is appealing, it is more complex than it may appear. To examine participant changes over time, one must use the following steps:

- The first and most important step is to choose which outcomes to track. The outcomes chosen should be concrete, measurable, and based on clearly articulated program goals. The outcomes should be related to participant behaviors that the program either explicitly tries to affect or that it would logically affect given the intervention and a youth's average program experience. Program goals can include such things as improved academic performance, and improved parental and peer relationships.

- The second step is to interpret the findings. A positive or negative change in an outcome, such as grades or school attendance, is not the same thing as a positive or negative program impact. The impact of a program is its effect on participants beyond what would have happened to them without the program. The change observed in mentored youth must be compared with what their characteristics would have been without a mentor. And because one clearly cannot observe the outcomes for the participants themselves had they not received a mentor, the outcomes of another group of youth are compared to the participants.

The Summer Training and Education Program (STEP) provides an excellent example of how examination of outcomes can be misleading. STEP offered half-time work and half-time remediation to educationally and economically disadvantaged youth. The program goal was to increase the youth's academic competence. Over the summer, however, participants' test scores did not increase, but decreased slightly. It appeared that the program was ineffective. But, over the same period, the test scores of a control group of youth plummeted nearly a whole grade level.

Thus, STEP effectively stemmed the learning loss that typically occurred with these youth over the summer.

What do you do if you do not have a control group? Does this mean that measuring outcomes, without assessing effects by means of a control group, is without value? The answer is "no." General knowledge about how similar participants ordinarily do with respect to the desired outcomes can help form a reasoned judgment about a program's value. This technique does not provide knowledge as certain as that produced by an impact evaluation, but it is clearly useful and certainly better than no comparison at all.

Because the BBBS and SAS evaluations did track the outcomes of comparison groups, they provide extremely useful information about how key outcomes change naturally over time for various types of nonmentored youth. A program with similar or larger participant changes (serving similar youth) can justifiably infer that its program is also having a positive and significant effect.

Big Brothers Big Sisters

Changes in behaviors among those in the study who were not mentored show what changes in various outcomes over an 18-month period could be expected to occur naturally. Over this period, we found that for nonmentored youth:

- Scholastic competence scores (1 is low, 4 is high) increased by 0.24,
- GPA decreased by 0.13,
- They skipped 0.8 more days of class per year, and
- 11% started using drugs, and 27% started drinking alcohol.

Against this backdrop, we found that for the BBBS mentored youth:

- Scholastic competence scores increased by 1.18,
- Virtually no decrease in grades occurred,
- There was virtually no increase in skipping school,
- 7% started using drugs, and 21% started drinking alcohol.

From the BBBS impact study, we know that the program has a statistically significant impact on all of these outcomes. Thus, if a program serves a similar population of youth as those included in the BBBS study and the program finds changes in outcomes similar to or greater than those reported here, one could reasonably make the argument that the program led to improvements in those outcomes.

Sponsor-A-Scholar

Consider the changes observed among the older SAS sample. We found that among the youth who were not enrolled in SAS:

- Grade point averages (measured from 0 to 100) had decreased by 4.56 points from the beginning of ninth grade to the end of tenth,
- By the end of eleventh grade, grades were 5.27 points lower than they were in ninth grade,
- 64% of the comparison group members attended college the year after graduation, and
- 57% of the entire group was attending college two years after, graduation (including both new enrollees and returning students).

By contrast, we found that among the mentored SAS participants:

- Grade point averages had decreased only by 1.72 points from the beginning of ninth grade to the end of tenth,
- By the end of eleventh grade, grades were only 2.77 points lower than they were in ninth grade,
- 85% of the mentored youth attended college the year after graduation, and
- 73% of the entire group was attending college two years after graduation (including both new enrollees and returning students).

As with the BBBS sample, we find that grades for these youth tend to decrease over time without any extra intervention. The mentoring and services provided by SAS mitigated much of the decline and greatly increased the percentage of youth who attended college in both the first and second years after high school. If a program similar to SAS finds that its participants' grades remain fairly stable through high school and a similar percentage attends college, then it is likely that it is also having a significant effect on its youth's academic achievements.

Summary

In the sections above, we presented and discussed several measures that mentoring programs can use to assess their own effectiveness. We explored three types of indicators that programs could use: descriptions of participant characteristics, measures of effective relationships, and changes in participant outcomes. Directly measuring change in specific outcome measures is what many think of as the only way to demonstrate program effectiveness. However, outcomes often change over time as a result of maturation, not because of the program. Thus, they are not as straightforward a tool as they appear. In order to interpret outcome changes correctly, operators need to have examples of typical changes against which they can compare the changes they measure. We hope this article has provided an insight on the techniques available to mentoring programs.

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Case Study—Calvin & Paul

Calvin's first reaction to the word "mentor" was nothing short of self-doubt. "When they asked me to join the program, the first thing I thought of was that I did not go to college. There is this perception that you have to be a great scholar to be a mentor, and I wondered how I was going to do it." But Calvin felt a desire to help young people and became a mentor anyway. He was matched with Paul, a senior. "My experience with Paul has shown me that the most important thing is to be committed. It has nothing to do with your education."

"In the beginning, we had a more structured relationship," says Paul. "It was mostly about me graduating from high school. Since then, it has been more about just talking, giving advice and planning. And it's become more of a friendship." For Paul, both the challenges and rewards of the relationship swing on Calvin's efforts to keep him focused. "Calvin always gives me quality advice," he says. "The hard part is making good on it. I do not always follow through."

This story was excerpted from the *How to Be a Great Mentor Guide*, developed by The National Mentoring Partnership with *Newsweek* Magazine and Kaplan Educational Services.

Mentors' Contributions to Gifted Adolescents' Development

By Kerry M. A. Casey, M.A., and Bruce M. Shore, Ph.D.

Research on mentorships for gifted adolescents has primarily focused on the roles mentors play in students' academic success. Mentors' contribution to the affective, social, and vocational development of gifted adolescents' rarely has been addressed. This article identifies special needs and characteristics of gifted adolescents in these areas, and suggests how mentors can play a significant role in each, including the particular value of mentoring relationships for gifted adolescent females. Finally, educational implications are explored, as well as the need for empirical studies, which examine the benefits derived by gifted and nongifted mentees from mentoring relationships.

The term mentor appears to have originated from Homer's *Odyssey.* Before embarking on his 10-year journey, Ulysses entrusted the education and care of his son to his wise friend, Mentor. Thereafter, Mentor signified a respected and wise teacher who provided intellectual and emotional counsel to younger individuals. Today, the concept of mentoring similarly refers to a learning partnership between two or more persons who wish to share and develop a mutual interest. The mentor, typically an adult, acts as a guide, role model, teacher, and friend to a less experienced and often younger mentee.

Biographical reports, self-reports, and interviews indicate that mentors exert one of the most significant influences on gifted individuals' personal and vocational success.

Gifted students' thirst for knowledge may provide one explanation of why mentors play an instrumental role in the students' lives. Finding a mentor who challenges one to explore an interest may provide stimulation otherwise absent in a student's classroom experience. Many gifted students need to work in a subject area at a more in-depth, accelerated pace than that which is provided by the regular curriculum.

Perhaps even more interesting is research indicating that gifted individuals appreciate mentors' emotional guidance and social and vocational modeling just as much, if not more, than intellectual stimulation. Presidential Scholars reported that role modeling, support, and encouragement were the most important functions their mentors performed. This finding was unexpected as networking and other vocational tasks are typically regarded as the primary functions of mentors. In light of such reports, this review examines the role that mentors play in gifted adolescents' affective, social, and vocational development, given their special needs and characteristics.

Affective and Social Characteristics of Gifted Students

Research suggests that differential affective characteristics exist among the gifted. Gifted students are often faced with feelings of social isolation and inadequacy due to unsatisfactory interpersonal relationships. Moreover, intensity, heightened sensitivity, and perfectionism are often characteristic of gifted students. Mentors can offer emotional support and serve as role models for dealing with such tendencies that can become problematic. They can help students objectively evaluate and set realistic objectives regarding their talents, and help them deal with the risk of capitalizing on the wrong abilities.

Gifted children often interact successfully with adults due to their advanced affective and cognitive development. Such students are also good candidates for mentoring programs due to their ability to work independently and autonomously, and their high level of motivation. Appropriate mentoring for highly able pupils differs in important ways from how teachers normally provide instruction in school. In the classroom, one is taught several unrelated topics each day, over short periods, by various teachers. Conversely, development of a talent evolves differently, with individualized, continuous instruction taking place over extended intervals—the type of instruction a mentor is able to provide.

Vocational Development

There is strong research support for the need for career education for the gifted. Of particular relevance to highly able youth are the potential impact of high aspirations, focus and dedication, the moral issues associated with certain careers, and the concentrated educational investment they must often make. The pursuit of certain careers often prolongs the attainment of financial independence and delays marrying and having children. These concerns are especially relevant to gifted children because they, more often than others, follow these types of careers.

Mentors exert one of the most significant influences on gifted individuals' personal and vocational success.

Mentors are also helpful for learners who excel in multiple areas or who have multiple interests. Gifted and talented adolescents may have few opportunities to discuss decisions regarding career choices even though they may require more information and personal insight from adults who are involved in the students' areas of interest.

Equally, high level occupations require creativity and the ability to deal with problems that do not have known solutions. Mentorships can play a critical role in ensuring that gifted and talented students have opportunities to develop such inquiry-related, higher level thinking skills.

Unfortunately, gifted adolescents' special needs for career counseling are often overlooked by school personnel who feel that these students are smart and will succeed on their own. In other instances such input is received, but much later than when it is required. Those who do not receive counseling may allow parental or societal expectations to excessively determine their career paths. For instance, in one study, students who scored highest on the American College Testing had a limited conception of their vocational options. Engineering, medicine, and law were the choices most often cited, suggesting that gifted students are drawn toward high status occupations. For example,

some students whose primary interests rested in the humanities pursued engineering studies.

The Value of Mentorships for Gifted Females

Successful female mentors serve as role models for gifted female students, providing them with the intellectual and emotional support they require. Gifted females often fail to achieve their potential in order to better fit in with their peers. They often lack teacher and parent support because as females, they are not expected to excel, particularly in mathematics and the sciences. The impact of a mentor is particularly effective in ensuring that women remain in science.

Research supports implementing mentorship programs at the elementary and secondary school levels. One study found that gifted girls initially achieved higher grades and more awards than their male counterparts. By adolescence, however, these females had lower vocational aspirations than the males. Gifted females' career aspirations and achievements have been observed to decline even further during college and after graduation. Early educational experience, challenging learning pace, individualized instruction, and mentoring are among the experiences which eminent women suggest as significant in their lives and careers. Furthermore, other research found that nearly three times more female than male mentees reported that they made focused career decisions as a result of their mentoring experience. Female mentees were also more likely than males to report increased self-confidence in their vocational and personal capabilities, and development of new skills.

Gifted individuals appreciate mentors' emotional guidance and social and vocational modeling just as much, if not more, than intellectual stimulation.

Conclusion

Mentoring experiences can significantly contribute to the emotional, social, and vocational development of gifted adolescents. This may be particularly true in the case of gifted females. Since very able youth may start the process of vocational decision making before adolescence, the process of mentoring might need to begin in upper elementary grades and be more closely tied to the provision of vocational information.

Gifted students who have had mentoring experiences value and benefit from them tremendously. They need the guidance of adults no less than any other pupil. Mentorships extend the curriculum, and they do so in ways that are valued by bright children, that lead to personal growth, and that capitalize on strengths such as cognitive ability and the ability to relate well to adults. The mentoring literature compliments well the instructional literature in gifted education by highlighting several ways in which the instructional needs of gifted pupils need to be adapted, such as building inquiry-guided curriculum around students' interests.

Up to this time the literature has addressed the advantages of mentoring versus not mentoring, but not the outcomes of more or less successful mentorships, especially with very able youth. Equally, there are parallel literatures on mentorships in the studies of personal management, and in women's studies. These have not been fully explored for the benefit of young people, especially gifted young people, in terms of theoretical context, mentor role, or optimal timing of mentorship experiences. Cross-age studies would help specify key variables of such research, and both retrospective and longitudinal studies could enrich our understanding.

Clearly, more research is needed to sharpen our understanding of the ways in which mentorship programs may offer uniquely appropriate educational experiences for gifted students, and what, within that or apart from it, may constitute appropriate mentorship experiences for all students. ◄

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WEB RESOURCES

Juvenile Mentoring Project
www.ojjdp.ncjrs.org/jump

The mission of the Juvenile Mentoring Project (JUMP) is to support one-on-one mentoring programs for youth at risk of educational failure or delinquency. It is supported by the Office of Juvenile Justice and Delinquency Prevention. This web site contains information about the project, how to receive funding, who the grantees are (including contact information), information about the evaluation being conducted by Information Technology International (www.itiincorporated.com/Project_Pages/JUMP/jump.htm), publications about the project, and links to other resources.

National Mentoring Center
www.nwrel.org/mentoring

The National Mentoring Center is funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP). The mission of the Center is to create connections between children and caring adults in the community by working in conjunction with OJJDP's Juvenile Mentoring Program (JUMP) and collaborating with Big Brothers Big Sisters of America, Public/Private Ventures, and Information Technology International (ITI) to provide resources, training, and evaluation services to assist in the mentoring process. There is access to the NMC training curriculum "Strengthening Mentoring Programs," the National Mentoring Center "Bulletin," and links to other resources.

The National Mentoring Partnership
www.mentoring.org

According to its web site, the National Mentoring Partnership is "an advocate for the expansion of mentoring and a resource for mentors and mentoring initiatives nationwide." This site provides information on how to become a mentor, ideas on activities to enjoy with the mentee, how to become a better mentor (including the online course "Learn to Mentor"), information on how to run a mentoring program, and numerous other resources.

Family Mentors and Educational Resilience Among Native Students

By Margaret Waller, Ph.D.

It is well known that mentoring plays an important role in educational resilience for kids whose positive adaptation is jeopardized by multiple risk factors. Before exploring mentoring and educational resilience, however, it is necessary to clarify the concept of resilience. Historically, a clear and useful definition of resilience has eluded prevention researchers. Early scholars suggested that resilience was an intrinsic characteristic of fortunate individuals, for example, the"teflon coated" child who does well in spite of the presence of risk factors, such as growing up in the context of deprivation or abuse. This definition suggests that other children are vulnerable because of psychobiological factors or early deprivation related to relationship or environmental factors. These were the "unlucky ones," who didn't have the "right stuff,"and were therefore prone to negative adaptational outcomes. In my view, this deterministic view of children is neither accurate nor conducive to effective prevention efforts.

Alternatively, a strengths oriented perspective, suggests that while every person is vulnerable, and likely to "break" given the right kind and number of adverse life circumstances, every person is also resilient and potentially responsive to positive life circumstances. Resilience is not an intrinsic characteristic that some people have and others do not. It is the product of favorable circumstances in which protective factors buffer the adverse effects of risk factors. Moreover, adversity is not necessarily a bad thing. While every person has a "breaking point," many people grow in healthy ways, not in spite of adversity, but because of it.

The discontinuity between indigenous and dominant culture worldviews creates a sense of disorientation and distress for many Native students.

Promoting educational resilience is integral to prevention of maladaptive outcomes for children and adolescents in general, but is a particularly pressing need for Native students. The discontinuity between indigenous and dominant culture worldviews creates a sense of disorientation and distress for many Native students. Moreover, students from reservation communities may feel pressured to choose between traditional and the dominant culture values. Given these cultural discontinuities, it is not surprising that Native students are particularly vulnerable to negative educational outcomes.

Substantial evidence suggests that children of adversity who are educationally resilient typically have had a mentor watching over them. A mentor is typically an older, more established member of a social system (e.g., extended family, organization, community, etc.) who "claims" the protégé and makes a conscious commitment to be that young person's guide over time. The mentor becomes a continuous presence in the protégé's psycho-affective life, seeing potential, challenging, encouraging, demonstrating, as well as providing resources and access.

To date, research on mentoring has focused largely on relationships outside of the family, for example, between established members of organizations and communities and junior members in need of guidance. Curiously, elder members of kinship systems, although obvious and natural potential mentors, are a resource that has remained largely unexplored because many mainstream prevention researchers are uninformed about normative practices among non-dominant groups. This is unfortunate, given that family mentoring is a long-established aspect of many cultures.

In the Diné (Navajo) kinship system, for example, mentoring is a birthright. As in many indigenous societies, the Diné believe that human beings are inextricably interconnected through a complex web of relationships, including relatives by blood, clan, tribe, and adoption. Among the Diné, interdependence and cooperation are givens; and individual standing in the community is largely related to the extent to which a person fulfills his or her responsibilities to relatives. To be Diné is to meet one's responsibility to one's relations. This is why one of the harshest forms of retribution is to be told, "You act as if you have no relatives."

Among the Diné, it is expected that the maternal uncle will mentor his sisters' children. In many families, his role responsibilities include shepherding his nieces and nephews through their education. Teles, for example, is a young attorney and a college professor in a large metropolitan area in the Southwest, several hours drive from his tribal home on the Navajo reservation. Since his 6 nieces were in grade school, Teles has consistently modeled educational resilience and inspired them to set goals and achieve in school. He challenges them, demystifies the dominant culture and its manifestations within the educational system, and provides them with both emotional and material support as they progress through each phase of their educational development. Guided by Teles, the three eldest graduated from their border town (the town adjacent to the reservation) high school a year early and subsequently moved to the city where Teles lives. Currently, four of his nieces, one of whom has an infant, live with Teles in his home in the city. Heather, an eighth grader, is continuing her education via home schooling as she undergoes her second round of chemotherapy for bone cancer. Esther, Brenda, and Millie are all currently enrolled in college. As Teles puts it, he "walks them through the system." For example, Esther became discouraged by an unpleasant interaction with a member of the university support staff who, Esther believed, was refusing to release her transcript to the four-year college to which she was hoping to transfer. Teles was there to run interference:

> Esther has been having the worst trouble with the community college. They weren't releasing [her transcript]. So I thought my presence might make a difference. They were very rude to her… very rude to her. They said, "It's you again? Didn't we have this discussion?" So, I went there and I sat down with her and I told the registrar who I was, "This is my student and I understand that there were some communication problems here. I just want to make sure that her questions are getting answered."

In another instance, Teles guides Brenda in decision making related to her academic/career path:

> I'm kind of their academic advisor—for example, Brenda—we've had several discussions so far about, "What do I do? Do I want to get out of college as quick as I can and get myself a Bachelor's degree? Or do I take an extra year to do something that I only have maybe forty percent interest in, which is teaching elementary school?" So we talked about it, and talked about it, and talked about it, and we weighed all the pros and cons. And I just left it up to her. I think she's ready to get her degree and then go into a graduate program. My own experience is that I really didn't get focused until I finished my graduate degree program—my masters in education. That's where I really wanted to be—that's where I wanted to steer my career. And so I think that perhaps that'll work for her as well. She is interested in Native studies. She has a lot of credits in that area, and she can finish within three years. And then she can always go back to get her teaching certificate if she decides to go back to education. Getting a college degree means a whole lot, especially if you're a young Indian person...

Natural mentoring has been a given in Diné families, as in many non-dominant cultural groups, particularly those who have preserved their traditional ways of life despite pressures to discard their traditions and assimilate into the American mainstream. As Teles puts it:

> I was always told in my family—culturally—give, give, give. These are my sister's children. I don't see them as any different than my own children—it's just who we are as a family unit... They're doing well academically... very well academically... and I think that they have a game plan.

The natural mentoring that occurs in this family is not exceptional among the Diné. Although it is often overlooked by helping professionals, mentoring is an existing or potential resource in many families across cultural groups. While prevention researchers and practitioners make a substantial contribution by exploring and developing formal mentoring programs, it is also important to recognize, respect, and collaborate with natural mentors within a young person's kinship network. This is particularly true for kids from Native and other non-dominant cultural groups because they often face a hostile social/psychological climate in grade school, high school, and college, and are therefore particularly in need of prevention efforts such as recognizing and recruiting natural mentors who have the potential to foster educational resilience.

Margaret Waller, Ph.D., is an associate professor at the School of Social Work, Arizona State University, Tempe, Arizona. Her research and teaching center on individual, family, and community resilience and inter-cultural understanding with particular emphasis on Indigenous Peoples of the Southwest. She has also been a practicing family therapist since 1982.

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Making Mentoring Relationships Work

A number of studies have looked at mentoring relationships to better understand why some matches are successful and others are not. One question is particularly important: What can mentors themselves do to ensure that a relationship is more likely to succeed? The findings are fairly consistent about practices of effective mentors compared with those of less successful ones.

The key to creating effective mentoring relationships lies in the development of trust between two strangers of different age groups. Volunteers typically come to mentoring programs because they want to help youth. Without establishing trust, however, mentors can never truly support the youth with whom they interact. Learning to trust, especially for youth who have been let down before, requires time; youth cannot be expected to trust their mentor simply because program staff have put them together. Establishing communication and developing a relationship can often be a difficult process. Mentors who follow a gradual path in building trust find that the types of support they can offer, and that will be accepted, broaden considerably once trust has been established.

Mentors who focus first on building trust and becoming a friend to their youth tend to be more effective than those who immediately try to change or reform the mentee. Adults whose attention is concentrated on reforming youth are often frustrated by their lack of receptivity. These volunteers make the mistake of pushing too hard and too quickly on youth's problems—pressing them to talk about sensitive issues before they are ready and ignoring the youth's desire to help set the agenda for the pair's activities.

Effective mentors are more likely to engage in the following practices:

- They make a commitment to being consistent and dependable, to maintaining a steady presence in the youth's life.
- They recognize that the relationship may be fairly one-sided and take responsibility for keeping the relationship alive. Our research has found that youth often test adults to determine whether they will actually stick around.
- They respect the youth's viewpoint. Effective mentors are open and flexible; they listen to what the youth has to say and pay attention to what the youth thinks is important.
- They involve the youth in deciding how the pair will spend their time together. Although youth are often reticent, successful mentors take the time to learn about the youth's interests and provide them with options for how to spend their time, rather than planning everything without input from the youth.
- They pay attention to the youth's need for "fun."
- They tend to become acquainted with their mentees' families. Nonsupportive parents can sabotage these programmatic relationships; successful mentors have found it helpful to meet and interact with their mentees' parents. At the same time, mentors have to guard against involvement with the family to an extent that could be detrimental to their relationship with the youth.
- Finally, successful mentors seek and use the help and advice of program staff. These mentors recognize that they do not have all the answers and value the support and guidance that program staff can provide.

From C.L. Sipe. (1999). Mentoring Adolescents: What have we learned? In J. Baldwin Grossman (Ed). *Contemporary Issues in Mentoring*. Philadelphia, Pennsylvania: Public/Private Ventures. It appears here with permission. The complete report is available online (www.ppv.org).

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Mentoring Lesbian and Gay Youth

Lesbian and gay youth are generally invisible. Along with the many other problems that adolescents must deal with, they often face profound feelings of social and emotional isolation that have been linked to increased rates of depression and suicide, substance abuse, and other self-damaging behaviors (see *The Prevention Researcher* Vol 8(1), for more information on lesbian and gay youth).

While Training Mentors:

During training sessions, trainers often focus on the particular kinds of issues the youth in their program may be facing. Since it is likely that at least some of the youth in your program are lesbian or gay, it makes sense to integrate information about their particular challenges into your training session. Examples include:

- Discuss your organization's policy on diversity.
- Discuss your organization's confidentiality requirements.
- Discuss what participants would do if their mentee revealed that they were lesbian or gay.
- Help mentors become aware of their own attitudes toward people whose sexual orientation is different than their own.
- Practice communication skills, guiding them to use inclusive language, especially non-specific pronouns.
- Include communication role-plays, in which some of the situations address homophobia and heterosexism.
- Provide information that will help mentors understand the particular risks faced by lesbian and gay youth.
- If you are training your mentors to deal with sexuality issues, be sure you address the sexuality of everyone.

Tips for Mentors:

- Do not assume that your mentee is heterosexual.
- Recognize that you cannot tell whether someone is straight or gay just by looking at him or her.
- Use inclusive language. Be accepting and open. (For example, try to use nonspecific pronouns when talking about your mentee's "crushes" or "romantic interests" until she or he mentions that person's gender.)
- Use the vocabulary the youth uses. (For example, if your mentee uses the word "gay" or "lesbian", use that term as well).
- Be supportive of mentees who identify as heterosexual but are attracted to people of the same sex.
- Be alert to any sudden changes in your mentee's attitude about homosexuality. (A youth who, for the first time recognizes his/her attraction to a person of the same gender is likely to feel confused and might react to these feelings by expressing anti-gay attitudes.)
- Be willing to talk to your mentee about sexual orientation.
- Maintain confidentiality.
- Educate yourself and provide accurate information.
- Remember that you are not a counselor.
- Be aware of your own attitudes toward, and stereotypes of, gay males and lesbians.

From L. Jocovy. (2000). *Mentoring Sexual Minority Youth.* Technical Assistance Packet #2. National Mentoring Center. It appears here with permission. For more information on this topic, the complete packet is available online from Public/Private Ventures (www.ppv.org).

UPCOMING TOPICS

- **Adolescent Grief and Bereavement**
- **Alcohol and Youth**
- **Teen Parents**
- **Resiliency**
- **Youth as Resources**

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Teens & Grief

By Donna Schuurman, Ed.D. and Amy Barrett Lindholm, M.S.

What is it like for teenagers when someone close to them dies? How do they respond to the death of a parent, a sibling, a relative, a friend? In our work, we've learned that teens respond to adults who choose to be companions on the grief journey rather than direct it. We have also discovered that adult companions need to be aware of their own grief issues and journeys because their experiences and beliefs impact the way they relate to teens.

People often confuse "grieving" and "mourning." Grieving refers to the internal experience of the teen, whereas mourning is the public expression of the internal grief. Keep in mind that when a teen loses someone significant, he or she is grieving whether you can see it or not. Like adults, a teen experiences a broad range of emotions and physical reactions after someone dies. Adults are sometimes surprised to notice that teenagers grieve differently than they do. For example, the death of a close teen friend may evoke more intense grief than the death of a grandparent. Adults who don't expect this may minimize the impact of the death of a peer because they don't acknowledge or understand the significance of this friendship to the teen.

Six Basic Principles of Grief

1. Grieving is a natural reaction to a death.
Even though grieving is a natural reaction to death and other losses, it does not feel natural because it may be difficult to control the emotions, thoughts, or physical feelings associated with death. The sense of being out of control that is often a part of grief may overwhelm or frighten some teens. Helping teens accept the reality that they can grieve allows them to do their grief work and to progress in their grief journey.

2. Each grieving experience is unique.
Grieving is a different experience for each person. Teens grieve for different lengths of time and express a wide spectrum of emotions. While many theories and models of the grieving process provide a helpful framework, the path itself is individual, and often lonely. No book or grief therapist can predict or prescribe exactly what a teen will or should go through on the grief journey. Adults can best assist grieving teenagers by accompanying them on their journey in the role of listener and learner, and by allowing the teen to function as a teacher.

3. There are no "right" and "wrong" ways to grieve.
There is no correct way to grieve. Coping with a death does not follow a simple pattern or set of rules nor is it a course to be evaluated or graded. There are, however, "helpful" and "unhelpful" choices and behaviors associated with the grieving process. Some behaviors are constructive and encourage facing grief such as talking with trusted friends, journaling, creating art, and expressing emotion rather than holding it inside. Other grief responses are destructive and may cause long-term complications and consequences. These include alcohol and substance use, reckless sexual activity, antisocial behaviors, and withdrawal from social activities.

4. Every death is unique and is experienced differently.
The way teens grieve differs according to their personality and the particular relationship they had with the deceased. For many teens, peer relationships are primary. The death or loss of a boy/girlfriend may affect some teens more than the death of a sibling or grandparent. Within a family each person may mourn differently at different times. This can generate a great deal of tension and misunderstanding within the already-stressed family. Each person's responses to death should be honored as his or her way of coping in that moment. Keep in mind that responses may change from day to day or even from hour to hour.

When a teen loses someone significant, he or she is grieving whether you can see it or not.

5. The grieving process is influenced by many issues.
The impact of a death on a teen relates to a combination of factors, including:

- Available social support systems
- Circumstances of the death (how, where, and when the person died)
- Whether or not the youth unexpectedly found the body
- The nature of the relationship with the person who died
- The teen's level of involvement in the dying process
- The emotional and developmental age of the teen
- The teen's previous experiences with death

6. Grief is ongoing.
Grief never ends, but it does change in character and intensity. Many grievers have compared their grieving to the constantly shifting tides of the ocean: ranging from calm, low tides, to raging high tides that change with the seasons and the years.

(Continued on Page 3)

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From the Editor's PC

Dear Colleagues,

Welcome to our spring issue of *The Prevention Researcher.* This issue focuses on adolescent grief and bereavement which our editorial team feels is an often ignored topic. Now, in light of the terrible September 11 tragedies, it seems even more relevant. This issue focuses on some of the interventions and strategies one may use both in the school and community setting to assist those youth who are in mourning and dealing with grief issues.

This issue begins with an article by Donna Schuurman, Ed.D., and Amy Lindholm, M.S. of The Dougy Center for Grieving Children in Portland, Oregon. Using their experience working with grieving youth, Dr. Schuurman and Ms. Lindholm give us an introduction into the teen grieving process and highlight some of the issues that may be involved.

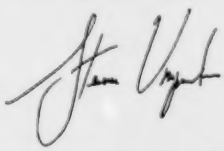
Dr. Charles A. Corr, Professor Emeritus from Southern Illinois University Edwardsville, follows with "Helping Adolescents Cope with Long-Term Illness and Death." Dr. Corr provides us with a framework with which to begin to understand teen bereavement.

This is followed with a look at two different kinds of adolescent grief. Dr. Julie Cerel, from West Virginia University, and her colleagues examine the impact of parent suicide, and Gordon Riches, M.A., from the University of Derby in Derby England, examines the impact of sibling bereavement.

And finally, this issue concludes with an article by Dr. David Balk, Professor at Oklahoma State University, who gives some insight into preventive interventions with grieving teens.

Although a difficult topic to approach and understand, we felt the need to find the best available literature for those who are working with the bereaved. We hope you will find it useful. As always, your comments are most welcome, both at our Web site (www.TPRonline.org) and in writing.

Have a great spring.



Steven Ungerleider, Ph.D.
Editor/Psychologist

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Recycled Paper

The "never-ending, but changing" aspect of grief may be the least understood. Most people are anxious for teens to have closure and "put the death behind them" so that they can go on. But death leaves a vacuum in the lives of those left behind. Life is never the same again. This does not mean that life can never be joyful again, nor that the experience of loss cannot be transformed into something positive. But grief does not have a magical closure. People report pangs of grief 40, 50, even 60 years after a death. Grief is not a disease that can be cured, but a process we learn to incorporate into our lives.

How Different Types of Deaths Impact Teens

The nature of the relationship and the cause and circumstances of the death impacts how teens grieve. Below we briefly highlight what some of these issues may be.

The Death of a Friend

Peer relationships frequently seem more important to teens than family relationships. Therefore, the death of a friend may significantly affect young people in ways parents and other adults may not understand. The death of a friend whom the parent never or seldom met may have little effect on the parent, but a huge impact on the teen. An adult who dismisses the impact of the teen's grief compounds strife with the teen and complicates the youth's grieving process. When a peer dies, teens are confronted with the realities of death, the possibilities of their own mortality, and feelings of being abandoned by close friends. Young people often believe that they are immune to death. They think that death only happens to old people. When a friend dies, their entire world and beliefs are shaken to the core.

Often teen friendships are up and down, on and off relationships. Grief complicates all relationships and ends up pulling people together or apart. After the death of a friend, some teens draw together to share their grief, while others are embarrassed and have difficulty sharing emotionally-charged grief. It is common for teen friendships to revolve around fun. Grieving is not fun. The grief that follows the death of a peer is compounded by the added loss of peer friendships and fun times.

Trust is built with teens by telling them the truth about how, when, and where a peer died. Secrecy, deception, half-truths, and lies, even when intended to protect, will often backfire, creating a wedge of suspicion and anger. Teens need to know the truth and should be trusted with the truth. If you don't know the facts, then "I don't know" is the truth.

The Death of a Parent

The death of a parent is usually a devastating, distressing experience in the life of a teen. When a parent dies, a young person's sense of security and stability in the world is turned upside down, regardless of the nature of the parent-child relationship. A parent's death disrupts the teen's life with radical complications. Suddenly the teen is different from peers and feels strange and alone. The death of a parent becomes the defining event in the teen's life. A teen begins to define his or her life in two categories: "before" or "after" the death.

Teens who have conflictual, even abusive, relationships with parents may experience a sense of relief, ambivalence, guilt or regret after a parent dies. An abusive or neglectful relationship compounds the distress because the death means the loss of hope and opportunities for restoring the relationship.

Often financial and daily living circumstances change radically when a parent dies, increasing the teen's feelings of instability and loss of control. Teens may have concerns about immediate physical and financial security. A parent or other adult can help by discussing the family's financial status, decisions, and plans for the future with them. Telling the truth and giving choices will assist grieving teens to regain a sense of control of their lives.

Grieving teens are also coping with the realization that they will not have a father or mother to celebrate rites of passage. You can help them by recognizing that those events will be difficult times without the parent. As those events approach, it is important to help teens consider creative ways to memorialize the deceased.

The death of a parent means the beginning of new life with a vulnerable, grieving parent, even if the parents were divorced. The teen left with only one biological parent is often also concerned, consciously or unconsciously, with the possible death of the surviving parent. Sometimes the remaining parent places unrealistic expectations and roles on the teen to take over parental functions. Or, sometimes the teen takes on these roles with no prompting from adults.

Grief is not a disease that can be cured, but a process we learn to incorporate into our lives.

The Death of a Sibling

The death of a brother or sister is significantly different from the death of a parent or another adult caregiver. Siblings are peers and experience a unique attachment as children of the same parents. Often siblings hold confidences for each other from the parents. Suddenly in many families the surviving child is "an only child" in a complex way that requires an unwanted adjustment of roles and relationships.

A Violent Death

When teens experience a violent death such as a murder, a drunken driving crash, or other violent acts that leads to death, their basic belief system is thrown into turmoil. Teens typically consider themselves and their families immune from such violent acts. Suddenly their innocence and certainties are shattered and their world no longer feels safe. Thoughts and feelings about the person who died and the person(s) who caused the death get mixed up and teens feel confused. Revenge and animosity toward the perpetrator can get in the way of truly grieving for the person who died.

People often harshly and unfairly judge the victims or their family after a violent death. This helps people protect themselves from believing that someone they love could die violently. People feel safe if they think that "bad things only happen to bad people." Obviously, this attitude alienates those who are impacted by a homicide or violent death.

After a violent death, people's curiosity and questioning can be intrusive and irritating to many teens. The initial media exposure may be sensationalized, promoting conjectures or outright errors that are never retracted or corrected. Sound bites and video clips don't give a significant explanation of what happened. Anger, resentment, bitterness, and frustration mount for the grieving teens not only toward the perpetrator but toward others in the community who rush to conclusions based on incomplete, and often inaccurate, information.

Another factor that may make coping more difficult after a violent death is the impact of the ongoing legal investigation and, potentially, a trial. Family members are told by police not to discuss the case with anyone, which makes it difficult to get support. Sometimes a family member is a suspect, which adds intense stress on everyone. Because of the time lag between the violent act and the verdict, many supportive persons move on with their own lives and are unable to support the family. Sometimes victims feel alone, forgotten, and isolated.

Death by Suicide

The act of suicide produces an array of unwanted thoughts and feelings toward the person who died and about the circumstances under which the death occurred. "Why?" seems to be the foremost question for teens who have had a friend or family member die from suicide. Thoughts of unfulfilled promises, disrupted relationships, missed warning signs and haunting unanswered questions relentlessly preoccupy the teen's mind. Real or imagined images of the final scene may persist and cause emotional turmoil.

Teens may be afraid that they are "fated" to die by suicide when a parent takes his or her own life. It is important to assist teens in understanding and developing other ways to cope with life's inevitable disappointments and difficulties. Teens also have a strong desire to understand and make meaning of the suicidal act. Because of society's general lack of knowledge about contributors to suicide, teens may have differing views about why the person died, and may even blame themselves. It is important to help them understand that suicides occur when a person's brain and thought processes are not working properly, much as liver disease may result when someone abuses alcohol, or heart disease when someone neglects their body. The diseased brain determines that suicide is the only escape from pain. Additionally, schools or communities, in an attempt to deglamorize suicide and prevent copycat suicides may discourage mourning or memorializing the person who died. This failure to acknowledge the life of the person may actually reinforce the survivor's alienation and support the suicide's belief that their life was no longer worth living. There are ways to acknowledge the life and death of a person who suicided without glamorizing the act itself. It is an opportunity to educate around warning signs and prevention that may be lost if schools choose to remain silent.

Multiple Deaths

Two types of multiple deaths may complicate the grieving and healing process for teens. Multiple deaths in a single incident like a car crash or school shooting may add an additional level of complexity to processing why such events occur, part of the necessary "meaning making" task of teens. A succession of deaths during a short period of time may also lead to bereavement overload, and a fear that no one is safe. Additionally, for teens involved in an accident or incident where others died and they lived, it is not uncommon to see "survivor guilt" among those whose lives were spared.

Death from AIDS

It has been our experience that teens who have had a parent or sibling die of AIDS usually feel uncomfortable talking about the cause of death due to the social stigma associated with AIDS. Teens may fear that if they do reveal that it was an AIDS-related death that they will be ostracized. Teens may also fear that people will judge them or their family through a perception that the death was "deserved" because of promiscuity, homosexual behavior or drug use. Because young people in this situation tend to hold their feelings inside, they may experience a higher level of physical symptoms and concerns about their own health.

Don't force the teen to share the cause of death with others unless and until he or she is ready to do so. At the same time, allow the teen to talk about the person who died and to memorialize the deceased. Once the teen is ready to discuss the cause of death, you may want to help him or her gain a thorough understanding of AIDS and to think through how to respond when someone is critical about the disease. Finally, teens often benefit from participating in support groups with others who have experienced an AIDS death.

Case Study – Brett

My mother was in many ways my best friend. We did almost everything together. She was sick on and off for seven years; she died when I was ten. In that respect, my loss was very different from the loss of someone in a car crash. I had a chance to say goodbye to my mother. However, I was forced to take care of her, physically and emotionally, as best I could. I was very scared. I had trouble sleeping, my grades dropped, I would be sitting in class and just start crying.

After my mother died, I moved and left my home, my school and my friends. These are all things that I am still working through. I started a new school in fifth grade. In my sixth grade year, I met Jonathan. Jonathan always had lung problems, but they were not very serious. We became good friends. At the end of sixth grade, he was absent a couple of days a week, and was in and out of the hospital. In March of seventh grade, we found out he was dead. None of us had expected it.

I felt awful! I had not visited him in the hospital enough, and I was too caught up in my own life to worry about him. I felt horrible. I also felt sad, mad, scared, and shocked. Our class organized a memorial service; everyone participated and made a wonderful service. It made me feel a little better about neglecting our friendship, and it helped me to pay homage to Jonathan. His parents really appreciated it, too.

There is nothing good about losing someone you love, but that doesn't mean that something good can't come out of it. When you lose somebody special, it is extremely important to talk about it with somebody. It may not always be the right time to talk, and your family and friends should respect that. But you must talk about it when you're ready. If you never express your feelings, they will build up, and they will eventually explode.

From B.H. Blake (2000). How I Coped with Loss. In K.J. Doka (Ed.), *Living With Grief: Children, Adolescents, and Loss* (pp. 123–124). The Hospice Foundation of America. Used with permission.

Death from Chronic Illness
When a family member's death is due to illness, teens sometimes develop fears around their own health, worrying that they too have the fatal disease or illness. After such a death, teens want to share common experiences around the dying process. They want to talk about things like hospitalization, medical procedures, emergencies, changes in personality due to an illness, and how illness affects relationships. Teens may also feel a sense of relief that the person died because the intense suffering and pain is over. This sense of relief, which may bring on more guilt or other accompanying feelings, needs to be normalized.

Accidental Death
Death from an accident often evokes fears around lack of safety, loss of control, powerlessness, and unpredictability. Accidental deaths may occur in a variety of circumstances including car accidents, work-related injuries, sports-related accidents, etc. Teens need to share what they have been told about the accident and what they think actually happened.

When a Teen Witnesses a Death
Witnessing a scene where someone dies or being threatened by a person or situation can result in stressful emotional and physical responses. It is especially traumatic for a teen to find the body after a murder or suicide. Being on the scene during emergency medical treatments can also be traumatizing. These incidents have dramatic effects on the mind and body of the young witness. Allowing the witness to express thoughts and feelings about the traumatic incident helps reduce its negative effects. Recounting the unfolding drama of the event and discussing his or her own perceptions helps the witness diminish the aftermath of the traumatic event.

In some cases, young witnesses should see a professional for a crisis debriefing and evaluation. It is possible for teens to experience a delayed psychological and physical reaction to a horrific event. Without some intervention, a teen may develop a post-traumatic stress disorder. Although the reaction may be delayed, the symptoms of this disorder result in future complications to the teen's normal lifestyle. Delinquent behavior may be one expression of this disorder.

Because teenagers are entering the phase developmental psychologist Erik Erickson refers to as "formal operational," their major focus is on establishing independence. Experiencing the death of a family member or friend complicates their struggle for identity, and they may pull away from parents and adults toward reliance on peers for what to think and how to act. The way adults can be most helpful to them as they journey through their grief process is to provide non-judgmental safety and assurance as they struggle for meaning. Pushing them to perform or act a certain way will likely push them away. Let them know you are available, and don't approach them as someone to fix or repair, but rather, allow your calming presence to support them in their feelings, whatever they are. If necessary, intervene when destructive behaviors emerge, but otherwise allow them to feel the pain, anxiety, and confusion, and to express it, or not express it, as they choose. If they trust you are safe and caring, they will allow you to walk with them as their grief journey unfolds.

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This article is condensed from *Helping Teens Cope with Death*, a guidebook from The Dougy Center. It is used here with permission from The Dougy Center (www.GrievingChild.org).

The Bill of Rights of Grieving Teens

A common topic raised by teens is their frustration with the lack of rights they have to grieve as teens. They feel that many adults strip them of rights that would benefit their grief process. At one of the teen groups at The Dougy Center, bereaved teens discussed a bill of rights for themselves. There was a great deal of discussing, arguing, rewording, and compromising before the final draft was agreed upon. Here is their final draft:

A grieving teen has the right to . . .

- ✔ Know the truth about the death, the deceased, and the circumstances.
- ✔ Have questions answered honestly.
- ✔ Be heard with dignity and respect.
- ✔ Be silent and not tell you his or her grief emotions or thoughts.
- ✔ Not agree with your perceptions and conclusions.
- ✔ See the person who died and the place of death.
- ✔ Grieve any way she or he wants without hurting self or others.
- ✔ Feel all the feelings and to think all the thoughts of his or her own unique grief.
- ✔ Not to have to follow the "Stages of Grief," as outlined in a high school health book.
- ✔ Grieve in one's own unique, individual way without censorship.
- ✔ Be angry at death, at the person who died, at God, at self, and at others.
- ✔ Ignore people who are insensitive bigots who spout clichés.
- ✔ Have his or her own theological and philosophical beliefs about life and death.
- ✔ Be involved in the decisions about the rituals related to the death.
- ✔ Not be taken advantage of in this vulnerable mourning condition and circumstances.
- ✔ Have irrational guilt about how he or she could have intervened to stop the death.

From *Helping Teens Cope with Death*, a guidebook from The Dougy Center (1999). It appears here with permission from The Dougy Center (www.GrievingChild.org).

Helping Adolescents Cope with Long-Term Illness and Death

By Dr. Charles A. Corr

It is useful to have a framework from which to begin efforts to help adolescents cope with long-term illness and death. One such framework can be drawn from five main factors that stand out in all experiences of grief:

(1) the nature of the prior attachment to a deceased person;

(2) the mode of death and concurrent circumstances of the survivor;

(3) the coping strategies that an adolescent has learned to use in managing previous losses;

(4) the developmental situation of a particular adolescent; and

(5) the availability and nature of support on which the adolescent can draw.

Prior Attachments

Attachments are special relationships serving basic human needs. Attachments are significant for all human beings, but they are particularly important for adolescents. While adults can often form alternative attachments or find other ways to satisfy their needs when a particular attachment ends, adolescents are likely to be far more dependent on a limited set of attachments, often with peers who themselves may have little experience with death, and may lack the ability to seek out new and helpful attachments on their own.

Several features of attachments are important for understanding a bereaved adolescent. First, attachments are often multidimensional. If so, reactions to the loss of such attachments may also be multidimensional. A bereaved adolescent may respond (perhaps over time) to each aspect of what has been lost, both the primary and the secondary losses, in ending the attachment. Insofar as an adolescent is able, he or she will mourn each important aspect of the lost attachment and its related grief reaction.

Second, attachments are commonly depicted as warm, nurturing relationships, but that is not always the case. Some attachments are complex or dysfunctional. For example, an adolescent may be dependent upon a mother who is distracted by depression or the use of addictive drugs, or upon an abusive father who takes out his frustrations on youngsters in his family. The ending of such attachments may leave a bereaved adolescent with a complicated and difficult grief reaction.

Third, attachments are sometimes only fully appreciated after they have ended. Previously, it may not have been evident how important the attachment figure was in the life of an adolescent.

This suggests that helpers should explore with a bereaved adolescent his or her attachment to the deceased person, both in itself and in its role as a foundation for grief. This can be done by listening carefully to the adolescent's expressions of grief and to his or her comments about the attachment figure. Gentle inquiries may take the form of questions, such as: "What did you most like (or dislike) about the [attachment figure]?" "What is it that you miss now?" "Why do you miss those things?" "Are there other aspects that you do not miss?"

Over time, a helper might ask additional questions, such as: "How has your life been changed by the death of this person?" "How has your family been changed?" "Who takes care of your needs now?" "What alternative relationships now serve to meet your needs?" "What other relationships might be established?"

In addition to verbal questions like this, some helpers use art, play, puppets, and other modes of symbolic interaction. The important point is not the specific technique but its effectiveness in assisting the bereaved adolescent and the helper to appreciate all that was significant in the attachment and all that is important in the grief reaction.

In cases of long-term illness and dying, helpful interventions are not confined solely to the post-death period. When someone is dying there is an understandable tendency to focus on his or her needs. That can become problematic when it leads people to overlook the everyday needs of adolescents and the special issues they face in connection with the long-term illness and death of a significant other. Helpers who can intervene prior to a death should address the needs of the young survivor-to-be, strive to acknowledge or strengthen healthy bonds with the dying person, try to prepare for what is to come, and seek to develop a foundation for future memories and legacies. Even if an adolescent is unable or unwilling to visit a dying person directly, tapes, phone calls, videos, or other links can provide a symbolic presence. Helpers who contact a bereaved adolescent after a death should ask what things were like for the youngster during the dying process and what important changes took place in his or her life before the death.

Sudden, unexpected, traumatic, and human-induced deaths are likely to be shocking, disorienting, and present difficult challenges to survivors.

Mode of Death and Concurrent Circumstances

Sudden, unexpected, traumatic, and human-induced deaths (e.g., accidents, homicides, and suicides) are likely to be shocking, disorienting, and present difficult challenges to survivors. By contrast, long-term dying may make it difficult for adolescents to deal with the depletion of energies involved in chronic illness and dying or the challenges of living through a series of crises and returns to health (e.g., with AIDS and its opportunistic infections). Also problematical are experiences involved in witnessing an individual's disfigurement or deterioration (e.g., in some forms of facial cancer), loss of functional capacities (e.g., in neurological diseases such as Parkinson's disease or Lou Gehrig's disease), or loss of personality prior to physical death (e.g., in Alzheimer's disease). Adolescents who have been excluded from or who do not have close contact with the dying person may perceive the death as if it had taken place very quickly.

Within a family system, adolescents are often asked to put their own needs aside in favor of those of others or to take on the

roles of a deceased or dying person in ways that may sometimes exceed their capacities. Also for adolescents, there are often issues such as those related to responsibility ("Did I somehow cause Grandpa's cancer?"), blame ("Did Uncle Ted's AIDS result from his lifestyle?"), and guilt ("Did I wish my father would go ahead and die so that the rest of us could get our lives back?" or "Why am I relieved that my mother's death is finally over?"). In some so-called "dying families" adolescents who are themselves not ill may have to struggle with a series of life-threatening illnesses (e.g., related to HIV infection), losses, and deaths in a relatively short time. Sometimes, adolescents find themselves in the very difficult situation of being confronted by multiple deaths at the same time, for example, when multiple family members die in a single automobile accident. In addition, a bereaved adolescent may simultaneously be contending with other stressors such as abusive or inadequate parenting at home, poverty in the neighborhood, violence at school, and dislocations involved in foster care or institutionalization.

Helpers can begin by exploring with a bereaved adolescent his or her knowledge of and concerns about the illness or mode of death of a loved one. Start with active listening and empathetic inquiry focusing on what the youngster has been told about the dying or death of a loved one and what are his or her main concerns. Go forward by: a) providing accurate information about the illness or mode of death and its related circumstances; dispelling misinformation and myths; b) working with parents and other family members to mobilize family values and develop religious or philosophical frameworks that help a bereaved adolescent make sense out of or find meaning in the death; c) facilitating the identification of strong feelings and other reactions to the encounter, and venting them in constructive ways; and d) working with the youngster to develop and implement appropriate commemorative activities to memorialize the life of the person who has died.

Helpers can also work with bereaved adolescents to explore other events or aspects of their lives that may contribute to making a death-related experience more or less difficult. Being handed over to new caregivers, moved to a new neighborhood, transferred to a new school, or asked to cope with a new parental figure in place of one who has died can all complicate the bereavement of an adolescent. Often helpers may work directly with the adolescent. Sometimes it may be sufficient to draw the attention of parents and other family members to the needs of the adolescent.

Coping Strategies

Coping refers to constantly changing efforts to manage challenges perceived as stressful. When an illness or death is perceived as stressful, an adolescent may attempt to manage its impact in a variety of ways, for example, through play or sports, crying or clinging, or turning away from the harsh reality.

Adults who seek to help bereaved adolescents should explore two main points: What are the important sources of stress for an adolescent's grief? And, how can an adolescent best be helped to improve his or her coping with those sources of stress? With respect to sources of stress, much will relate to strains on an attachment, mode of death, and concurrent circumstances. With respect to how the adolescent is coping, one can explore how the youngster has coped with stressful situations in the past, who his or her role models in coping have been, and what he or she has learned about coping.

Helpers are unlikely to effect major changes in an adolescent's coping strategies, even within the extended time frames of long-term illness and dying or in their aftermath. Nevertheless, understanding how and why the youngster has coped and is coping can guide the helper in interactions with the adolescent. From this foundation, helpers can assist significant adults to help an adolescent with his or her coping. And all who are helping can work to model, teach, and develop constructive coping tactics. Small improvements in coping with loss and grief, both before and after a prolonged illness or death, may lead to immediate and long-term benefits in the well-being of a bereaved adolescent.

Developmental Situation

All human beings face normative or predictable tasks in the course of their lifelong development. Specific developmental eras, tasks, and conflicts have been identified within adolescence (see Table 1). Appreciation of this developmental background is of great value in understanding bereaved adolescents.

TABLE 1

Tasks and Conflicts for Adolescents by Maturational Phase

Phase I — Early Adolescence	
Age:	11–14
Task:	Emotional separation from parents
Conflict:	Separation (abandonment) vs. Reunion (safety)
Phase II — Middle Adolescence	
Age:	14–17
Task:	Competency/Mastery/Control
Conflict:	Independence vs. Dependence
Phase III — Late Adolescence	
Age:	17–21
Task:	Intimacy and Commitment
Conflict:	Closeness vs. Distance

SOURCE: Fleming, S.J., & Adolph, R. (1986). Helping Bereaved Adolescents: Needs and Responses. In C.A. Corr & J.N. McNeil (Eds.), *Adolescence and Death* (pp. 97–118). New York: Springer. P. 103.

Long-term illness, dying, and death add non-normative or specific situational challenges that may interrupt or complicate the work of normative development in adolescence. For example, an early adolescent focusing on decreased identification with parents (as well as increased identification with peers, fascination with hero figures, and sexual interest in peers) may find it difficult to cope with an elderly parent who seems to be withdrawing or separating from the teen as a result of a progressive life-threatening disease. Likewise, a middle or late adolescent pursuing intimacy and enriched relationships with his or her parents may find these difficult to achieve when one parent dies of cancer, the other remarries within six months, and a new stepparent comes onto the scene.

The key issue is how adolescents understand, cope with, and integrate loss, death, and grief into their lives. Helpers can begin by inquiring how death-related events have affected the youngster's development and in what ways developmental capacities have hindered or facilitated the youngster's abilities to cope with these situational challenges. To do this, one must be sensitive to the

full range of human development (not just cognitive or affective dimensions), listen to the individual adolescent, recognize the influence of his or her life experiences, and pay close attention to his or her modes of communication.

From a broader standpoint, helpers should be alert to developmental changes in the adolescent during an illness/dying process or after a death. And from an even more extended point of view, helpers will want to recognize and help the particular adolescent appreciate that issues associated with development in later life may reactivate grief or unfinished mourning. For example, an early adolescent may pine for guidance and reassurance from a long-dead parent when he or she begins dating.

Availability and Nature of Support

During a long-term illness or in the immediate aftermath of a death, there may be little if anything that can be done to alter the prior attachment, mode of death, concurrent circumstances, or an adolescent's developmental situation. Some specific coping tactics may be changed or redirected in the near term, while broader coping strategies may be reshaped in more productive ways over the longer term. Limitations facing helpers are apparent in each of these factors that affect the grief and bereavement of an adolescent.

By contrast, there is great latitude in the availability and nature of the support that is or may be offered to a bereaved adolescent. Questions to ask about availability might include: "Is any support available to the bereaved adolescent?" "If so, when is that support available, how is it offered, and by whom?" Sometimes the answers to these questions are that no support is available, or that if available it is only offered in limited or unpredictable ways, grudgingly or conditionally, or from unreliable sources.

All too often, adults who are preoccupied by their own grief or who have been drained of their energies by a long-term dying process may not appreciate an adolescent's need for support or may not be able to provide the support that is needed. This often takes place when the grief of an adolescent extends over a long period of time but is not made visible or is only expressed intermittently.

Helpers can do much to support bereaved adolescents, both directly and indirectly. They themselves can provide some of the support that may be needed by such an adolescent. As advocates, they can call upon parents and other adults for assistance, as well as on formal or informal networks involving other relatives, neighbors, schools, and religious or other communities. Where it seems appropriate (usually when the adolescent is having difficulty with everyday living or age-appropriate behaviors), they can refer a bereaved adolescent to a bereavement support group or an experienced grief counselor/therapist.

This last point is a reminder that many individuals and organizations can help bereaved adolescents. Helpers might draw upon individuals with special skills, as well as on organizations with expertise related to adolescents, those which serve bereaved youngsters and others who care for them, or those mobilized around the diseases that lead to long-term illness and dying in our society (e.g., hospice programs). Beyond this, there is now available an extensive body of literature about bereavement in adolescence, as well as print and audio-visual resources for children, adolescents, and those who care for them.

Conclusion

Adults can do much to help bereaved adolescents in cases of long-term illness, dying, and death. Understanding the impact of these encounters on bereaved adolescents and helping such adolescents can be guided by attending to the five factors examined in this article. In truth, however, helping bereaved adolescents is primarily a matter of effective communication, prior education (whenever possible), validation of the youngster's needs, and caring support. Specific knowledge and professional skills are especially relevant to instances of complicated bereavement. In most other cases, helpers function best by honoring the youngster's grief, upholding the confidence that bereaved adolescents have the natural capacity to cope with loss and grief, and trusting that difficult events in life can become opportunities for growth.

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Condensed from Charles Corr (1997). Coping with Long-Term Illness and Death in an Adult: The Impact on Grieving Children and Adolescents. *Living with Grief: When Illness Is Prolonged.* Hospice Foundation of America. Reprinted by permission of Hospice Foundation of America.

UPCOMING ISSUES

Alcohol and Youth

Alcohol use is associated with the three most prevalent causes of death and disability among youth (including deaths due to motor vehicle crashes, homicides, and suicides). Alcohol use is also associated with more frequent (and often unprotected) sexual activity among youth. According to the National Institute on Alcohol Abuse and Alcoholism, individuals who experience alcohol-related problems (such as motor vehicle crashes and assaults) are light or moderate drinkers. Our September issue will focus on adolescent alcohol use, giving special attention to prevention.

Adolescent Sex Offenders

Studies of adult sex offenders suggest that many of them began their sexually abusive behavior in their youth. The youth who commit sexual offenses are very heterogeneous, as are the acts they perpetrate. While many prevention programs have focused on educating potential victims, very little has been done to prevent youth from offending in the first place. Our November issue will look at the characteristics of adolescent sex offenders and current strategies for preventing youth from sexually offending.

Resource Issue

This year's Resource Issue will include an interview with Dr. Randa Ryan regarding athletes and eating disorders, and a Q&A with Caitlin Ryan, M.S.W. regarding lesbian and gay youth. You can read Ms. Ryan's article "Lesbian and Gay Adolescents: Identity Development" online (at www.TPRonline.org) and submit your own questions for the Q&A.

Other future topics include teen parents, youth as resources, and resiliency.

Suicide of a Parent: Child and Adolescent Bereavement

By Julie Cerel, Ph.D., Mary A. Fristad, Ph.D., A.B.P.P., Elizabeth B. Weller, M.D., and Ronald Weller, M.D.

In the United States, 7,000 to 12,000 children experience parental suicide annually, but few controlled studies have documented the course of bereavement for children and adolescents who lose a parent to suicide. For adults aged 25–44, the age group most likely to have children in the home, suicide is the fifth leading cause of death. Clinical lore suggests that parental suicide may contribute to serious psychological impairment as these children grow. Suicide-bereaved children must make sense of their parents' decision to end their own lives and must deal with the stigma surrounding suicide in addition to dealing with their grief.

The majority of previous research has focused on adult family members and friends who have experienced the suicide of a loved one. This literature leaves unanswered questions of whether bereavement from suicide is different from bereavement from other types of death. Children who have experienced the suicide of someone close to them may be particularly vulnerable to the development of psychopathology, especially depression. Several studies have examined clinic-referred suicide-bereaved children and found that children bereaved from the suicide of a parent or friend experience depressive symptoms; families with chronic turmoil; and responses that were sad, guilt-laden, and withdrawn; or angry, hostile, and defiant.

In the only previous comprehensive study of children grieving the suicide of a parent, parents of 36 suicide-bereaved children were interviewed. Families had higher rates of disruption (including marital separation and legal trouble) in the home before the suicide than randomly selected non-bereaved controls. Children's functioning was related to family turmoil in that children from families with marital separation, trouble with the police, surviving parents with abnormal personalities, or multiple school changes functioned less well five to seven years post-death. However, the children were not directly interviewed.

Approximately 95–98% of individuals who kill themselves are suffering from a mental illness, most notably depression and/or substance abuse, and most families in which an adult suicide occurs experience other chronic family stress such as physical illness, monetary or legal trouble. Previous research indicates that five years after the suicide of a spouse, surviving parents appear to have few mental health problems.

For survivors of suicide, social support may be reduced due to the stigma associated with suicide. In many religious traditions, suicide has been stigmatized, and the death is treated differently by the community. Feelings of guilt, blame, shame, or anger may cause the bereaved individual to retreat even from other family members, causing a sense of disconnectedness from the person who has died, family members and the community. Community members often appear unsure of how to treat individuals bereaved from suicide. Survivors often feel less support or rejection from their community.

Methods

As part of a longitudinal study of 360 children bereaved from parental death of all types, we followed 26 suicide-bereaved (SB) children from 15 families for two years after the death of a parent. SB children were compared to non-suicide-bereaved (NSB) participants who had also experienced parental death. This is the largest study to date in which both SB children and their parents were interviewed about their experiences pre- and post-death and followed over time. Half of participants were girls. Ages ranged from 5 to 17 years (average 11.7). Socioeconomic status ranged from upper to lower class and averaged middle class. Most children (85%) had a father suicide. Families were recruited through daily examinations of obituaries from local papers and from contact with local funeral homes. Approximately one-third of eligible families chose to participate when contacted by phone. Ninety-eight percent (98%) of participant families were Caucasian. No child had experienced sibling death. All had experienced the death of only one parent. Children and their deceased parent had regular contact over the two years pre-death.

Children and their surviving parents were evaluated separately approximately one month after the death of one of the child's parents. Comprehensive one to three hour face-to-face interviews were conducted simultaneously by different interviewers in the family's home or at the study center. The initial interview assessed symptoms, emotions, and events which had occurred since the death as well as functioning in the month pre-death and over the child's lifetime. Families were recontacted and interviewed again 6, 13, and 25 months after the death. "Late entry" families were also allowed into the study. These were families who initially refused participation, stating they were "too busy" when contacted in the month post-death but who consented to be interviewed at six months.

In the United States, 7,000 to 12,000 children experience parental suicide annually.

Results/Discussion

Grief Reactions. The death of a parent, regardless of cause, results in feelings of sadness, anxiety, and anger as well as acceptance for many bereaved children. Suicide-bereaved children are more likely to experience anxiety immediately after the death followed by anger at six months and shame by one year post-death relative to NSB children. They are less likely than NSB children to report feeling relief immediately after the death or "accepting" by one and two years post-death. Similarities between SB and NSB children in regard to their grief reaction might reflect a societal trend towards decreased stigma about mental illness as well as suicide which helps normalize the grief process for SB families.

Post-Traumatic Stress. While one might expect SB children to experience the kind of post-traumatic stress experienced by survivors of interpersonal violence, SB children were no more likely than NSB children to experience Post-Traumatic Stress symptoms as a result of the death. In our community sample, few children actually saw their parent's suicide. Thus suicide,

per se, is not necessarily associated with PTSD unless direct exposure occurs.

Psychiatric Symptoms. No differences were detected between SB children and NSB children in suicidality, self-reported depressive symptoms or severity of the symptoms related to depression. 37% of bereaved children experienced symptoms equivalent to a depressive episode at one month, and 31% experienced clinically significant symptoms at six months. This highlighted the importance of delineating the specific effects of parental suicide versus the general impact of parental death on children's outcome.

SB children report more pre-death psychopathology than NSB children. In the first month after the death, SB and NSB children showed equivalent levels of symptomatology. This suggests that the stress of losing a parent is initially more salient than the specific cause of the death. SB children did show more overall symptoms of psychopathology than NSB children from the six month to the 25 month interview. SB children appeared more behaviorally dysregulated than NSB children, due perhaps, in part to the disruption they experienced at home prior to the death. Thus, losing a parent to suicide might be associated with more long-term adjustment problems.

The long-term impact of parent suicide is still not known.

Psychosocial Functioning. Behavior at school, peer relations, and self-esteem did not differ substantially between groups. Teachers did not rate SB children as considerably more impaired than NSB children.

Families. Parental suicide can occur in a variety of family "types." These include "chaotic" families (47%); families in which the deceased appeared to have "encapsulated" psychopathology and the remainder of the family functioned fairly well (33%); and "functional" families, in which the suicide occurs in the context of a chronic medical illness or other healthy family (20%).

Those parents who committed suicide experienced significantly more behavior and mood disorders than did parents deceased for other reasons. However, surviving SB parents' rates of psychopathology did not differ from those of surviving NSB parents prior to or after the death. SB families showed a higher degree of family disruption than NSB families. However, most of this disruption occurred pre-death. This includes increased rates of divorce, mental health treatment, and general psychosocial stressors. SB families were more likely than NSB families to enter the study late, probably due to this turmoil.

SB children's relationships with their deceased parents may have been compromised. According to parental reports, SB children participated in significantly fewer activities with the deceased parent than did NSB children. The high divorce rate in these families coupled with a poorer quality of parent-child relationship with the deceased parent suggests that the suicide completer was not able to maintain a quality relationship with their child. Parental divorce may actually have reduced the impact of the deceased parent's psychopathology on their children, as children no doubt had less exposure to their parent's problems and their subsequent decision to suicide.

Fortunately, SB parents seem able to be competent parents despite the significant stress they and their family have undergone. The quantity and quality of one-to-one activities in which surviving SB parents participated with their children did not differ from the quantity and quality of such interactions reported in NSB families. This suggests that a diminished relationship with the deceased, coupled with a sufficient relationship with the surviving parent, may serve as a buffer for SB children.

When overall family activities were examined, SB families did less together prior to and after the death. SB parents might have been more likely to engage in one-to-one interactions but they were less likely to initiate activities with the entire family if multiple children were experiencing substantial behavioral difficulties.

Social Support. No significant differences were detected between SB and NSB children's experience of social support. Suicide has become less of a stigmatized event in the last 20 years, and survivors have been increasingly allowed to grieve openly and to carry out usual religious ceremonies. All SB families had at least one religious service following the death. There may be more subtle ways in which stigma affects survivors that might negatively impact SB children. Anecdotal comments from several study participants suggest SB children and their parents feel some stigma around the suicide.

Clinical Implications

Individuals who commit suicide are quite likely to suffer from psychopathology. Overall, spouses or ex-spouses of individuals who commit suicide are not likely to exhibit overt psychopathology. In fact, these parents seem to be able to somewhat buffer the impact of the deceased's relationship with their children. However, SB children do suffer more psychopathology than their surviving parents. The children examined in this study have not yet passed through the age of risk for the development of severe psychopathology. As these children enter adulthood, they might be at increased risk for mental illness and suicidality. Thus, programs to assist surviving parents with their children's reaction to parental suicide might be useful.

At this time, the long-term impact of parent suicide is still not known. Longer-term follow-up of SB children as they enter early adulthood is necessary to fully determine the impact of parental suicide during childhood on adult outcome and how families weather the suicide of a parent over time.

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This article is condensed from: Cerel, J., Fristad, M.A., Weller, E.B. & Weller, R.A. (2000). Suicide-Bereaved Children and Adolescents: II. Family Functioning. *Journal of the American Academy of Child and Adolescent Psychiatry,* 39(4), 437-444; and Cerel, J., Fristad, M.A., Weller, E.B., & Weller, R. (1999). Suicide-Bereaved Children and Adolescents: A Controlled Longitudinal Examination. *Journal of the American Academy of Child and Adolescent Psychiatry,* 38(6), 672-680. It appears here with permission from the original publisher, Lippincott Williams & Wilkins.

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Problems of Adjustment for Bereaved Siblings

By Gordon Riches, M.A.

In recent years, there has been a growth of research describing the impact of bereavement on children and adolescents. However, this research has mainly concentrated on youth who have experienced the death of a parent, creating an approach that sees problems of bereaved youth primarily in terms of their developmental stage, rather than in terms of the particular relationship they held with the deceased family member.

The sibling relationship is unique. It is usually the longest, and in some ways, the most taken for granted social connection an individual will ever experience. Its loss has consequences for self-identity, for personal development, for relationships with parents, with surviving siblings, and with others throughout adult life. A child's death is hard for parents to anticipate or prepare for, and when it occurs, they may be unable to support each other, never mind finding the reserves to appreciate what their surviving children may be going through.

Problems Making Sense of the Death

Research suggests that many parents will deny children information about the sibling's death in the misguided belief that they are too young to understand, or that they should be protected from the full force of the death. Evidence illustrates that lack of attention, lack of parents' own emotional resources, and preoccupation with the dying or deceased child, relegate surviving siblings to the sidelines, encouraging them to be, at best, passive spectators. Often partially developed conceptual and emotional skills prevent younger children from understanding or articulating how they feel, and adolescent identity problems further camouflage the distress of surviving older children and young adults.

Opportunities to create a "narrative" of the death are crucial. Reasonable access to all the facts of the dying, and to the disposal of the body, have been shown to be of immense value in providing the basic material from which the sibling's own story of the death will be constructed. Without this information or anyone with whom to share it, children may be thrown back onto their own imaginations. Our research indicates that these visualizations are often far worse than the truth.

The Impact of Sibling Bereavement

Many bereaved siblings describe intrusive thoughts during the day, and sleeplessness or disturbing dreams during the night. Fear of their own death may greatly increase. Feelings of uselessness and lowered self-esteem, isolation, exclusion, self-blame, and guilt are common. There is also evidence of pronounced and rapid mood swings and oscillation between apparently different stages of grief. Many siblings describe a sense of no longer being cared for, a loss of attention, loss of normal routines, loss of confidence, and lack of understanding of their feelings by peers or teachers.

Bereaved siblings appear to have a higher risk of psychiatric disorders in later childhood and adult life, with a greater tendency toward depression in cases of traumatic death. Studies of the impact of sibling loss in twins show levels of grief of similar—and in some cases even greater—intensity to that of bereaved parents or children bereaved of a parent.

It is likely that the nearer the deceased child was in age to the surviving sibling, the greater the sense of identification and, consequently, the more fundamental the challenge to his or her capacity to make sense of the world. The death of older siblings—or of children who died even before the youth was born, may create severe identity problems.

The longer term effects of traumatic loss within the family appear to be more anxiety, greater dependency, problems of individuation in later adolescence and difficulties of letting go in early adulthood. Research suggests that the death of a sibling is one of the most traumatic and least understood crises that adolescents can encounter.

Sibling bereavement has been linked to depression and to behavior problems in later life. Research suggests that there is not only an increased sense of vulnerability on the part of the surviving sibling, but also feelings of guilt about being alive and happy.

Research suggests that the death of a sibling is one of the most traumatic and least understood crises that adolescents can encounter.

Factors Affecting Adjustment

A number of studies show that the ability of the family as a whole to cope with a child's death effects the quality of surviving siblings' adjustment. Full access to information, opportunities to openly share feelings, and closeness of family relationships all contribute to the siblings chances of making sense of the death and integrating it into their own self-narratives. Bereaved siblings' grief will be expressed more openly if they perceive their social networks as loving, respectful, and caring toward them. Bereaved siblings especially value family conversations that confirmed the "continuing" relationship between the family and the deceased child.

Researchers Bradach and Jorden argue that it may not be the death itself but the damage caused by the death to the family system that ultimately affects siblings' adjustment. Parents' capacity to cope appears to be a central factor. While the death appears to leave some siblings more vulnerable to social and psychological problems, others seem to achieve a greater maturity and enhanced sense of the value of life. Bereavement can bring families closer together as well as drive them further apart. The role of social support and opportunities for making sense of their loss are important factors in helping determine whether bereaved siblings become "resilient" or "vulnerable" survivors.

Problems of Adjustment

Loss of security, of a sense of permanence, and of innocence will each figure in the changes to which the bereaved sibling has to adapt. They become aware of their own vulnerability and perceive distraught parents as proof of adults' inability to protect them.

The depth of their parent's distress may shock them. Parents may mistakenly believe that hiding details of the death will spare surviving children from further pain. At the same time, adults also appear to consistently overestimate the amount of information they have passed on to their children, having neither the patience nor the emotional reserves to ensure that explanations have been heard or understood.

Healthy brothers and sisters may feel shut out from the intense dynamic between terminally ill children and their parents. Information about the illness may be withheld, familiar routines of "home" may be disrupted and the entire family appears to be preoccupied and emotionally fragile. After the death, siblings may find themselves either left out or the object of intensified anxiety and over-protection. In time they might become the object of the aspirations parents had for the lost child, never being able to live up to what the dead child was or what he or she could have become.

Developmental Issues

Children express grief differently than adults, yet are crucially dependent upon them for exploring, confirming, and checking out their gradually dawning realization of death and its irreversibility. It is one of the chief ironies of sibling grief that the very people on whom the child is most likely to depend for successful adaptation are themselves the least emotionally equipped to recognize or deal with this need. Yet, as we have noted above, children's ability to cope appears to be directly linked to parent's ability to cope.

Researchers Lewis and Schonfeld argue that many children, like some adults, see events in terms of "natural justice" assuming that whatever happens must be a consequence of someone's actions—good being rewarded, wrong being punished. Hence, when a death occurs, for whatever reason, it is all too easy for parents to overlook children's feelings of guilt because of a particular act or thought they believe "caused" this retribution. Parents who actually accord blame to surviving children may amplify these feelings and help create major long-term obstacles to successful grief resolution. In cases where a sibling's actions relate directly to the death (such as firearm accident or failure to supervise younger brothers or sisters) it may be impossible for the family as a whole to 'work through' and come to terms with the loss without substantial external support.

David Balk suggests that one of the consequences of the characteristically adolescent mixture of anger, detachment, and denial is a particular form of "lingering grief" where the adolescents are reluctant to reflect on what their dead brother or sister meant to them. Many children may not possess the conceptual ability to process their grief reactions, and so carry their search for a satisfactory explanation of the death into each new developmental phase. He argues that this "unfinished business may accompany them well into adulthood and beyond."

Case Study – Deborah

Deborah was thirteen when her brother was killed in a boating accident. She said that she talked often with her mother after the death: "We talked about why. Why did he die? And what am I supposed to do?" Several of her brother's friends wanted to talk to her after the accident: "Mostly about how I was and how the family was doing. Then next came what did I feel like and what really happened. I wanted to talk with them because they were the people we knew best. And I felt comfortable with them. They were like, Ed's friends, because they knew him first."

In the immediate aftermath of the death, Deborah had worried that her family would disintegrate, but they became a major source of support for each other. She said that two years of coping led her to learn a lot more about life and to appreciate that if a brother dies, "all these different stages of feelings you go through are normal. That you are not crazy."

From D.E. Balk. (2000). Adolescents, Grief, and Loss. In K.J. Doka (Ed.), *Living with Grief: Children, Adolescents, and Loss* (pp. 35–49). Hospice Foundation of America. Used with permission.

Social and Relationship Issues

Sibling identity, quality of family relationships, and lifestage of the family as a whole must each be taken into account when explaining variation in bereaved childrens' and adolescents' adjustment, and in deciding on appropriate forms of support.

The more family members talk about the death, the greater are the chances of meaning being created. Younger children, with less coherently developed models of the world may be faced with major challenges of meaning. Hence opportunities to process thoughts, contradictions and fears are crucial. Parents, however, may be unwilling or unable to share their feelings and thoughts, and very reluctant to discuss the details and causes of the death. This may be especially so with miscarriages or still-births that occurred before subsequent children were born. In turn, adolescent children may themselves be embarrassed or uncomfortable about talking openly with parents.

Following the death of a sibling, children lose both a companion and a rival. The closer the relationship between the siblings—the more their life-space was shared—the greater will be the loss of their own identity. Adjustment to sibling loss may be affected by how much the deceased brother or sister helped define the boundaries of the survivor's own life. In the case of twins, this life-space may have been virtually identical, and each may well have relied almost exclusively on the other to reinforce the boundaries of their shared world.

Cultural Issues

Feelings of guilt and rehearsal of imaginary chains of events that justify self-blame, even in the face of evidence to the contrary, appear to be a central and recurring characteristic of sibling grief. The cultural imperatives of sibling bonds are symbolized in myths stretching from biblical legend, such as Cain and Abel, through to the more contemporary themes of "Catcher in the Rye," "Rain Man," and "The Waltons."

Siblings' guilt and confusion at the breaking of these bonds may be repressed because of parents' distress and their preoccupation with the dying or dead child. Surviving siblings can feel unloved and unwanted, noting with meticulous detail, the withdrawal of their parents into their misery. Parental conversations about the deceased child, their feigned interest in the surviving

sibling's day at school, their lack of concentration, and the drifting gaze all reinforce the unspoken sense in the survivor that "It should have been me." This sentiment—spoken with a mixture of exasperation, guilt, rebellion, and jealousy—is frequently noted by researchers.

The part played by brothers and sisters in "foraging" for a teenager's identity should not be overlooked. Older siblings can provide valuable role models that younger ones attempt to emulate or work hard at avoiding. Their own personal growth and development is intricately bound up with that of their siblings and the unique contribution each makes to the family's dynamic. The death of a sibling, whether during childhood, adolescence, or adulthood, radically affects this dynamic, forcing all the survivors to renegotiate their relative positions.

Families Where a Child Has a Life-Threatening Illness

For families where a child has a life-threatening illness, relationship stresses increase as the illness progresses. Siblings can come to feel more and more invisible and isolated. Brothers and sisters of children with life-threatening illnesses who become ill themselves, with colds or other childhood ailments, are frequently sent away from the family in order to keep the ill child safe from infection. While this appears sensible, for the siblings this can be yet another indication that their parents are only concerned with the severely ill child.

Following diagnosis, the parents' whole world is likely to be taken over by an intense fear of the future. Their time is taken up by consultations, hospital stays, and sometimes distressing medical treatment. They become "experts" in the illness, acquiring familiarity with drug regimes, medical language, nursing processes and all aspects of the treatment. Within the acute hospital setting, many parents shoulder immense responsibility for ensuring their ill child receives the "best" service. These parents know that on occasions they are unfair, and that their other children are sometimes overlooked or excluded. No matter how much awareness they have, the well children can be highly sensitive to feelings of blame and lack of worth.

From diagnosis, the child who is in need of special care and attention will change the family's dynamic. This can happen on many levels, but generally each member's grip on previously cherished assumptions about their lives and relationships, including marriage and parenthood, may be weakening. At school, teachers may ask about the ill brother or sister, but may not think to ask how the pupil is coping.

Sometimes siblings feel they need to prove their worth by becoming "super siblings," taking everything in their stride, being selfless, and providing love and support for their ill brother or sister. Much of our experience with these children and young people confirms they harbor an underlying and highly ambivalent sense of anger which is compounded by their guilt and frustration at being unable to give vent to it.

Conclusion

Siblings may benefit enormously from opportunities to be involved in the care of their ill brother or sister and by parents acknowledging the difficulties the family faces as a whole. By trusting children with their own uncertainties about the future and by passing on as much information as is available, well siblings can remain at the heart of the changing family dynamic, and can continue to contribute to its shape and character.

Sometimes siblings feel they need to prove their worth by becoming "super siblings."

Our practical experience of working with these siblings indicates that parents may sometimes need outside support in fully recognizing the depth of their feelings of exclusion. Mutual support amongst siblings from different families is invaluable. Opportunities to share resentments, their sense of exclusion, anxieties about parents, fear, and jealousy over ill siblings can help reduce their sense of isolation and allow them to recognize general patterns that all families adopt during such a crisis. The involvement of a concerned adult, with knowledge of the illnesses and of typical family responses to it, can help by validating these feelings and offering insights into why individual family members are coping so differently.

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WEB RESOURCES

All Kids Grieve
allkidsgrieve.org

All Kids Grieve is a resource for teachers, parents, counselors, and other adults. It includes links to curricula regarding grief and bereavement, information about starting a support group, lists of related books, and links to other sites.

Compassionate Friends
www.compassionatefriends.org

According to the Web site, the mission of Compassionate Friends is to "assist families toward the positive resolution of grief following the death of a child of any age and to provide information to help others be supportive." This Web site includes a number of useful brochures including such varied topics as "Stillbirth, Miscarriage and Infant Death," "When an Employee is Grieving the Death of a Child," and "Suggestions for Teachers and Counselors," among many others. Some brochures are available in Spanish.

KIDSAID
kidsaid.com

According to the Web site, "KIDSAID is a safe place for kids to share and to help each other deal with grief about any of their losses." There are a number of resources here for both kids and adults, including a question and answer session. This Web site is a companion site to Griefnet.org.

GrievingChild.org
www.GrievingChild.org

The mission of GrievingChild.org is to provide support to grieving children, teens, and their families as they move through the healing process. The GrievingChild.org Web site includes different sections for adults and youth. The adult section includes information on how to help a grieving child or teen, what to do when death impacts your school, and information about kids and funerals. The youth section includes separate areas for kids 12 and under, and those 13 and over.

Adolescent Bereavement and the Domain of Prevention

By David E. Balk, Ph.D.

Bereavement researchers have made some significant advances in our understanding of the dynamics and the processes of managing grief. In this article I will present three of these advances that are central to a discussion of adolescent grief and of preventive interventions. Preventive interventions encompass the three overall approaches used in public health and applied to community mental health by Gerald Caplan:

- Primary prevention to prevent the onset of mental health problems;
- Secondary prevention to overcome risks of serious disorders still in their incipient stages; and
- Tertiary prevention to assist people who are recovering from a serious disorder.

Each of the following approaches is viable in programs aimed at assisting organizations and individuals to manage bereavement and have been discussed by the author in other writings.

1. Increasingly, both clinical and research evidence indicate that on-going attachment to the deceased marks the lives of some persons managing their grief. Such ongoing attachment, termed "continuing bonds," lies in sharp contrast to the received dicta from experts such as Freud and Bowlby that managing grief requires detachment from the deceased. This phenomenon of continuing bonds has been noted in some adolescents grieving the deaths of siblings, parents, or friends. While some grieving individuals do remain attached to the person who died and do not show any signs of pathology, on-going attachment has not been made a norm or standard for all to experience.

2. Another advance in understanding has been the realization that bereaved individuals manage their bereavement not only by confronting the pain and distress of grief. We now realize that persons in grief oscillate between experiencing the distress of their loss and going on with their lives; in short, at times they focus directly on what the loss entails for them—they confront their loss—and at other times they take time off from grieving —they attend to living. Both processes are seen as crucial, adaptive, and normal following a loss.

3. A third advance has been the growing attention to the realities of adolescent bereavement. Whereas until the early 1980s scholars hardly, if at all, examined adolescent bereavement, there has been a burgeoning scholarship in this area, particularly since 1985, with most attention paid to bereavement following the deaths of parents and of siblings. Most studies of adolescent bereavement have not included comparison or control groups of non-bereaved adolescents, a limitation that is now being addressed in more recent work. Another limitation of adolescent bereavement research has been a reliance on cross-sectional, retrospective designs rather than longitudinal studies. Only recently have we begun to see careful studies of the effects of interventions aimed at helping adolescents manage their grief.

A Framework for Preventive Interventions with Bereaved Adolescents

We need enlightened and useful theory within which to fashion preventive intervention efforts aimed at bereaved adolescents. We need practitioners, who as active consumers of research, examine what scholarship has to say about adolescence and grief. Preventive interventions with bereaved adolescents need to synthesize and apply two theoretical frameworks: a theory of adolescent development and a theory of grief during adolescence.

Adolescent Development. Whereas there remains a societal expectation that adolescence ushers in a time of storm and stress, longitudinal and cross-cultural studies have noted that the adolescent years are times of relative calm and stability for the majority of youth. About a quarter (20-28%) of adolescents find adolescence a time of torment and come to the attention of clinical professionals and/or of legal authorities; some adolescents hide their desperation and camouflage their feelings of disturbance. Yet, these two groups of disturbed and troubled youths are not the norm for adolescent development despite Anna Freud's comments that the one thing normal about adolescence is its abnormality.

Adolescents are expected to begin resolving three developmental tasks: they are expected to select a career focus; they are expected to become an independent person; and they are expected to develop and maintain lasting and intimate relationships. Adolescents who are drifting and lack direction are experiencing difficulties in mastering one or more of these developmental tasks. Grief can threaten the completion of one or more of these developmental tasks. As an example, consider the position of a student whose grief obstructs concentrating on classes, produces isolation from others, and leads to disinterest in planning for the future.

Adolescent Bereavement. Grief manifests itself in many ways. It has physical manifestations such as fatigue and nausea; behavioral manifestations such as trouble sleeping and increased risk taking; cognitive manifestations such as difficulty concentrating and intrusive thoughts and images about the death; emotional manifestations such as fear and anger; interpersonal manifestations such as withdrawal from the presence of others and, as a corollary, reluctance of others to be in the presence of someone who is grieving; and spiritual manifestations such as a crisis in faith and doubt about the meaning of anything.

One approach that provides a useful means of seeing adolescent bereavement within the overall context of adolescent development is a model developed by Stephen Fleming and his colleagues at York University in Toronto. This model integrates developmental tasks and maturational phases of adolescence as critical ingredients for understanding the pervasive impact of grief during the adolescent years. Fleming emphasizes that managing adolescent grief requires a panoply of behavioral, emotional, and cognitive

responses vis-à-vis five principal issues of development. These five core issues are:

1. Trusting in the predictability of events;
2. Gaining a sense of mastery and control;
3. Forging relationships marked by belonging;
4. Developing self-confidence; and
5. Believing the world is fair and just.

J. William Worden used four of these core issues as means to understand the findings emerging in the two year study of grief following an adolescent's parent's death. His findings included:

• **Trusting in the predictability of events.** Bereaved adolescents manifested greater anxiety about the future than did non-bereaved adolescents.

• **Gaining a sense of mastery and control.** Particularly in the second year following a parent's death, bereaved adolescents indicated they felt they had diminishing control over what happened to them. There seemed to be a link here to their anxiety about the future and distrust about the predictability of events.

• **Forging relationships marked by belonging.** Bereaved adolescents indicated they were experiencing more social problems and were more socially withdrawn than non-bereaved peers, but they did not report having fewer friends than their non-bereaved peers.

• **Developing self-confidence.** Bereaved adolescents in Worden's study reported they had grown up because of coping with their grief and were more mature than their non-bereaved peers; however, they reported they felt "odd" within peer circles and reported their school work and their conduct was not as good as their non-bereaved peers.

• **Believing the world is fair and just.** Worden did not use this theme to examine his data. Not uncommonly bereaved adolescents have told me that the death of their sibling, parent, or friend taught them that "bad things do happen to good people" and taught them not to count on life being fair.

Three Important Issues

Three issues central to persons interested in preventive interventions with bereaved adolescents are the prevalence of adolescent bereavement, the "regrief phenomenon," and the place of spirituality in the management of grief.

Prevalence of Adolescent Bereavement. Adolescents are far more acquainted personally with death and bereavement than many people realize or perhaps wish to acknowledge. The situation of college students is a case in point. Surveys done at universities in the United States as well as in the Netherlands, Canada, and Australia have revealed consistently that a significant proportion of the students are in the first year of bereavement over the death of a family member or friend. By significant proportion I mean between 23–28%. The numbers would increase were you to include bereavement over other types of devastating losses such as the divorce of parents or the end of an intimate relationship with a boyfriend or girlfriend. Such rates of bereavement on college campuses clearly call for institutionally sponsored preventive intervention efforts to assist students to manage the grief they are enduring, if for no other reason than to help students remain in school and succeed in their studies.

The Regrief Phenomenon. Life contains several markers of development. As examples, consider graduating from high school, going away to college, graduating from college, becoming engaged, getting married, having children, and accepting one's first job in one's career. At each of these life events, persons who are bereaved report reliving in some respect their grief over the death of their loved one. The young woman whose father died and who is getting married is fully aware she does not have her father to walk her down the aisle. The young man whose girlfriend died and who is graduating from high school is fully aware he does not have his girlfriend to celebrate this accomplishment. There is a resurgence of grief, which may be as intense but does not endure as long as did earlier pangs of grief; and there is a press to incorporate the loss into this transition in one's life. It would be wise for prevention interveners to pay attention to this "regrief phenomenon;" a preventive tool to consider using is anticipatory guidance focused on getting grieving adolescents prepared for markers of development.

Adolescents are far more acquainted personally with death and bereavement than many people realize or perhaps wish to acknowledge.

Spirituality and the Management of Grief. Bereavement triggers in some persons a life crisis that shatters their trust that reality has any ultimate meaning; they lose hope and conclude that existence is absurd. The fundamental task of making meaning is at heart what spirituality is all about. Spirituality need not mean religion, though it can.

Adolescents are at a point in their lives when constructing meaning is at the crux of their efforts at forging a stable identity and at completing the developmental tasks that characterize adolescence. Preventive interventions need to take into account the various means whereby grieving adolescents are faced with making sense out of the loss they are enduring. Some adolescents, perhaps the majority, who are struggling to give meaning to the death they are grieving will trust in religion. There are empirical data that religion provides a means of coping with loss.

In our interventions we need to be open to discovering what frameworks of meaning inform bereaved adolescents, to listen attentively to their telling us what meaning they have found, empathize with them over the uncertain meanings of life, and not dismiss discussions of spirituality as signs of delusion.

Dr. David E. Balk, Book Review Editor for the journal *Death Studies*, is a Professor in the Department of Family Relations and Child Development at Oklahoma State University. He is a member of the Scientific Advisory Board working with the Center for the Advancement of Health regarding issues of grief, research, and policy implications.

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When Death Impacts Your School

Death can send shockwaves through a school, affecting the entire student population in different ways. Following are some lessons to help you bring the students through the difficult period. These lessons are excerpted from the books *Helping the Grieving Student: A Guide for Teachers* and *When Death Impacts Your School: A Guide for School Administrators* both available from The Dougy Center (www.GrievingChild.org).

Dealing with Grieving Students in Your Class

The following steps help support the grieving students as well as prepare your class for making the grieving student feel comfortable and supported:

1. Talk with the bereaved student before he or she returns. Ask what he or she wants the class to know about the death, funeral arrangements, etc. If possible, call the family prior to the student's return to school so that you can let the student know you are thinking of him or her and want to help make the return to school as supportive as possible.

2. Talk to your class about how grief affects people and encourage them to share how they feel. One way to do this is to discuss what other types of losses or deaths the students in your class have experienced, and what helped them cope.

3. Discuss how difficult it may be for their classmate to return to school, and how they may be of help. You can ask your class for ideas about how they would like others to treat them if they were returning to school after a death, pointing out differences in preferences. Some students might like to be left alone; others want the circumstances discussed freely. Most grieving students say that they want everyone to treat them the same way that they treated them before. As a rule, they don't like people being "extra nice." While students usually say they don't want to be in the spotlight, they also don't want people acting like nothing happened.

4. Provide a way for your class to reach out to the grieving classmate and his or her family. One of the ways that students can reach out is by sending cards or pictures to the youth and family, letting them know the class is thinking of them. If students in your class knew the person who died, they could share memories of that person.

5. Provide flexibility and support to your grieving student upon his or her return to class. Recognize that your student will have difficulty concentrating and focusing on school work. Allow the bereaved student to leave the class when she needs some quiet or alone time. Make sure that the student has a person available to talk with, such as a school counselor.

DOs and DON'Ts with Grieving Students

DO listen. Grieving students need a safe, trusted adult who will listen to them.

DO follow routines. Routines provide a sense of safety which is very comforting to the grieving student.

DO set limits. Just because students are grieving doesn't mean that the rules do not apply. Setting clear limits provides a more secure and safer environment for everyone under these circumstances.

DO NOT suggest that the student has grieved long enough.

DO NOT indicate that the student should get over it and move on.

DO NOT act as if nothing has happened.

DO NOT say things like:
"It could be worse. You still have one brother."
"I know how you feel."
"You'll be stronger because of this."

DO NOT expect the student to complete all assignments on a timely basis.

As a teacher, you have the opportunity to touch youth's lives in a very special way. Your actions have a lifelong impact. When a death influences the lives of your students, you and your school can make a lifelong difference by creating an environment for healing and support.

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Volume 9, Number 3, September 2002

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Alcohol Use Among Adolescents

by Michael Windle, Ph.D.

Adolescent alcohol use is statistically normative behavior in the United States. By their senior year of high school, the vast majority of adolescents have drunk alcohol at some point in their lifetime, with a substantial subset of adolescents drinking at high levels and experiencing a range of serious alcohol-related problems. On the basis of national survey data, the occurrence of a heavy drinking episode (i.e., having five or more drinks on a single occasion) was reported by about 25% of tenth graders and 30% of twelfth graders, and the average age of alcohol use initiation (or first drink) has decreased from 17.8 years in 1987 to 15.9 years in 1996. Alcohol use among teens has been associated with the three most common forms of adolescent mortality: accidental deaths (such as fatal automobile or boat crashes), homicides, and suicides. On average, eight adolescents a day in the U.S. die in alcohol-related automobile crashes, and nine out of ten teenage automobile accidents involve the use of alcohol. With a national school sample, suicide attempts were 3 to 4 times more likely among heavy drinking adolescents relative to abstainers.

In addition, alcohol use among adolescents is significantly associated with a range of other health-compromising behaviors. Higher levels of alcohol use are associated with more frequent, often unprotected, sexual activity among adolescents, which poses increased risk for teen pregnancy and sexually transmitted diseases, including potentially life-threatening diseases such as HIV. An earlier onset of alcohol use and higher levels of use among adolescents have also been associated with poorer academic functioning and higher rates of school dropout.

Adolescent Alcohol-Related Behaviors

The systematic, large-scale study of adolescent alcohol-related behaviors (for example alcohol use, alcohol problems, binge drinking episodes) is, historically and scientifically speaking, a relatively recent phenomenon. Among the most long-standing and well-known U.S. national studies of adolescent substance use (including alcohol use) is the Monitoring the Future Studies (MFS), which were initiated circa 1975 to provide national surveillance data on adolescent substance use practices. The MFS has provided annual national surveys of adolescent substance use practices and associated attitudes about various features of substance use (such as perceived harmfulness, perceived availability). Over approximately the first 20 years of the MFS, the annual survey samples consisted solely of high school seniors. In recent years, the MFS has expanded to include eighth and tenth graders; this is important because of historical trends in substance use that indicate an earlier age of onset for substance use among children.

The following presentation of epidemiological findings about adolescent alcohol use are based largely on the MFS; findings from other regional or local studies are used to substantiate other significant considerations.

The data provided in Figure 1.1 indicates that the prevalence of using alcohol increases across grade levels for three racial/ethnic groups. However, it is important to note that by eighth grade over 50% of these children report having consumed an alcoholic beverage. Racial/ethnic group differences indicate a particularly high prevalence of lifetime alcohol use among Hispanic children. Similar to findings in previous studies, black adolescents have the lowest rate of lifetime alcohol use. Research findings from earlier MFS cohorts and from other epidemiological studies have also indicated very high (if not the highest) prevalence of lifetime alcohol use among Native American children and adolescents, as well as quite low rates among Asian-Americans. Parenthetically, it should be recognized that drinking practices among adolescents (and adults) may vary considerably for subgroups (for example, for different Native American tribes, for Mexican-Americans versus Puerto Ricans) within the broad racial/ethnic groups used to present these data.

Alcohol use among teens has been associated with the three most common forms of adolescent mortality.

In addition to lifetime use of alcohol, another useful index of trends in adolescent drinking references heavy or binge drinking episodes. Binge drinking refers to the consumption of five or more drinks in a single setting over the last two weeks. In contrast to lifetime alcohol use, the binge drinking index is designed to assess potentially problematic drinking that may contribute to current problems (for example poorer school performance) and may be prognostic of longer term difficulties. The data presented in Figure 1.2 indicates both high rates of binge drinking and increases across grade levels. Differences are also indicated for the three racial/ethnic groups. Hispanic adolescents had substantially higher rates of binge drinking than whites or blacks among eighth graders. Black adolescents had the lowest prevalence of binge drinking across all three grade levels, substantially lower than their white and Hispanic counterparts. White adolescents had the greatest increases in the prevalence of binge drinking across grade levels.

(Continued on Page 3)

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From the Editor's PC

Dear Colleagues:

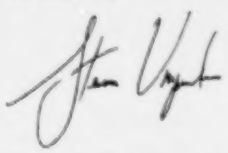
I'm delighted to present the latest issue of *The Prevention Researcher*. This issue delves into the topic of teenage alcohol use and the prevention models which address it. While current data is showing that alcohol use is remaining relatively steady, a third (32%) of high school seniors still report having gotten drunk in the past 30 days, and similar numbers (30%) report binge drinking (drinking five or more drinks in a row) in the past two weeks. It is, therefore, important for all of us to be aware of the prevention literature.

We have a terrific line-up of contributing authors from a wide spectrum of interests in the field of youth alcohol use. They include: Michael Windle, Ph.D., professor of psychology at University of Alabama, Birmingham; Cheryl Perry, Ph.D. and colleagues from the Department of Epidemiology at the University of Minnesota; W. Alex Mason, Ph.D., from the Social Development Research Group at the University of Washington; Chudley E. Werch, Ph.D. and colleagues from the Center for Drug Prevention Research at the University of North Florida; and Kathryn Stewart, M.S., a founding partner at Safety and Policy Analysis International, and formerly a senior research scientist at Pacific Institute for Research and Evaluation.

We hope you will find this issue of interest and useful in your work. As always, we have citations and other support literature on our Web site (www.TPRonline.org).

Feel free to visit us online and send us questions or comments about any of our newsletters (Feedback@TPRonline.org). We always appreciate hearing from our readers.

All the best,



Steven Ungerleider, Ph.D.
Psychologist/Editor

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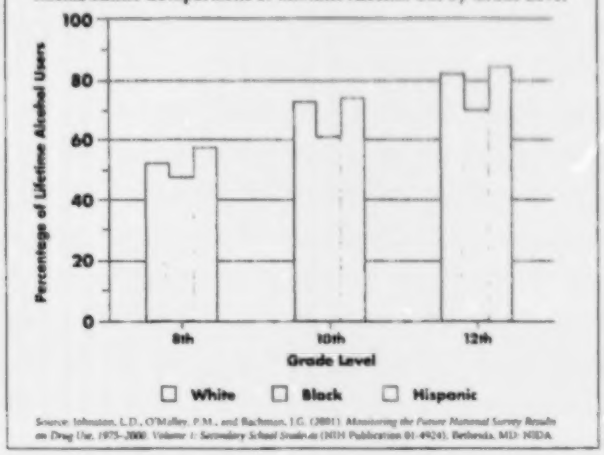
FIGURE 1.1

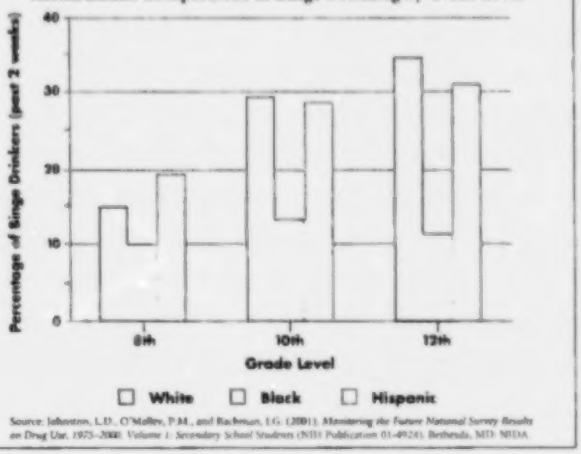
Racial/Ethnic Comparisons of Lifetime Alcohol Use by Grade Level



Source: Johnston, L.D., O'Malley, P.M., and Bachman, J.G. (2001). *Monitoring the Future National Survey Results on Drug Use, 1975–2000: Volume I: Secondary School Students* (NIH Publication 01-4924). Bethesda, MD: NIDA.

FIGURE 1.2

Racial/Ethnic Comparisons of Binge Drinking by Grade Level



Source: Johnston, L.D., O'Malley, P.M., and Bachman, J.G. (2001). *Monitoring the Future National Survey Results on Drug Use, 1975–2000: Volume I: Secondary School Students* (NIH Publication 01-4924). Bethesda, MD: NIDA.

While there is variability across grade levels and racial/ethnic groups, the prevalence of binge drinking among adolescents, considered collectively, is quite high.

Gender provides yet another potential source of variation among adolescent drinking practices. It has been proposed that historical shifts toward more gender equality in work and family roles among adults may be contributing to a convergence in drinking practices among male and female adolescents. If lifetime use is evaluated, there are few gender differences in alcohol use (80.9% of males vs. 79.5% of females report lifetime use). However, for more serious indicators of alcohol use, such as binge drinking and daily alcohol use, boys have a significantly higher prevalence than girls (36.7% of males report binge drinking compared to 23.5% of females and 4.7% of males report daily drinking vs. 1.1% of females). These findings are consistent with other studies in supporting the inference that boys are more likely than girls to engage in more serious levels of alcohol use (i.e., more frequently and at higher quantities) and to have more alcohol-related problems.

These epidemiological findings provide a broad picture of the drinking practices of adolescents. It is evident that the vast majority of adolescents consume alcohol at some time during adolescence, with a substantial number also engaging in binge drinking episodes. The study of more extensive alcohol problems among adolescents is a relatively recent phenomena, but the current data highlight high rates of such problems among adolescents. These alcohol problems are of concern because of their potential compromising influences on both current and future health functioning.

Adolescent Alcohol Disorders

As the preceding information demonstrates, data on adolescent alcohol use practices has increased substantially over the past 25 years or so. However, these national and regional survey studies have not included data on the number of adolescents meeting formal clinical diagnostic criteria for alcohol disorders. The available evidence, based on a few recent community studies, suggests that between 3% and 32% of adolescents meet lifetime criteria for an alcohol disorder.

In one study, 3–4% of adolescents between the ages of 14–16 years had an alcohol disorder. However, the prevalence of alcohol disorders of adolescents between the ages of 17–20 years was 8.9% for girls and 20.3% for boys. In another study, 32.4% of 386 older adolescents, mostly seniors in high school, had a lifetime alcohol disorder. Boys (37.6%) were more highly represented than girls (26.8%) with regard to the prevalence of an alcohol disorder. With a community sample of 3,021 adolescents and young adults in Munich, Germany, 25.1% of men and 7.0% of women had an alcohol disorder. Furthermore, the occurrence of alcohol disorders indicated low rates at age 13–14 years, with a rapid increase to a peak at 15–17 years, followed by a gradual decrease from 18–24 years. Cultural differences between the U.S. and Germany may contribute to this somewhat earlier onset of heavier alcohol involvement by German youth. Nevertheless, it is evident that the prevalence of alcohol disorders among adolescents is sufficiently high to merit increased concern and responsiveness from those concerned with the health and welfare of our youth.

Summary

Scientific studies of alcohol use among adolescents over the past 30 years or so have indicated high rates of usage as well as an earlier age of onset for alcohol use. More recent surveys have also indicated high rates of binge drinking and the manifestation of multiple alcohol problems. Although based on a limited number of local community studies, it has been estimated that between 3% and 32% of adolescents meet lifetime criteria for an alcohol disorder. These data clearly indicate the need for increased intervention efforts that target the initiation, escalation, and maintenance of alcohol use, as well as the treatment of alcohol disorders during adolescence.

Michael Windle, Ph.D., is professor of Psychology and director of the Center for the Advancement of Youth Health at the University of Alabama at Birmingham. This research was supported by Grant No. K37-AA07861 awarded to Michael Windle from the National Institute on Alcohol Abuse and Alcoholism.

This article is adapted from M. Windle (1999). *Alcohol Use Among Adolescents.* Sage Publications. It appears here with permission from the publisher, all rights reserved.

A Brief Alcohol Preventive Intervention for Student Athletes

Chudley E. Werch, Ph.D., Joan M. Carlson, M.S.W., Deborah M. Pappas, M.S.H., Patricia Edgemon, M.S.H., and Carlo C. DiClemente, Ph.D.

Relatively few studies have examined the alcohol and drug use of school athletes. Those that have indicate that athletes, particularly male athletes, when compared to nonathletes, are at increased risk for using alcohol, smokeless tobacco, steroids, and marijuana. In addition, it has been speculated that certain imputed risk factors for alcohol and drug misuse are more prevalent among athletes than nonathletes, including sensation seeking, the pressure of competition, "macho" male expectancies associated with drinking, and using alcohol and drugs to relieve stress.

Since annual preparticipation physical examinations are a prerequisite for competition in school sports, they represent a unique opportunity for primary health care providers to implement a range of screening and preventive services. We have found no studies examining the effectiveness of alcohol preventive interventions for adolescents attending sports physicals, even though the school sports physical is perhaps the most common setting in which primary health care professionals interact with adolescents, with tens of thousands of youth receiving sports physicals each year.

The purpose of this pilot study was to examine the feasibility and efficacy of a modified version of the STARS (Start Taking Alcohol Risks Seriously) for Families alcohol use preventive intervention for junior high school youth attending sports physical examinations. STARS for Families is a research project designed to test the effectiveness of brief alcohol "abuse" prevention strategies consisting of nurse consultations and parent prevention materials targeting at-risk youth.

Method

Subjects were recruited during physical examinations for sports programs at three schools in northeast Florida during the summer of 1997. Participants included 178 seventh to ninth grade students with 60 youths from one urban school, 74 youths from one suburban school, and 44 youths from one rural school. Just over half of participating youths were males (52%), and the majority were Caucasian (75%) followed by African-American (13.5%). Subjects were equally distributed among the three grades and were an average age of 13 years. Over half (55%) had tried alcohol sometime in their lives, with 28% having drunk alcohol during the last year. Subjects were randomly assigned within schools to either the STARS for Families intervention or a control. Six-month post-test data were collected at the school sites.

The STARS for Families intervention was modified to involve a telephone, rather than an in-person, nurse consultation discussing why and how the adolescent should avoid alcohol use. This was done due to the logistical barriers of providing nurse consultations to large numbers of youth converging at one time during prescheduled annual sports exams. Telephone consultations lasting about 20 minutes were conducted in the days immediately following the physical examination. Nurses who were present during the physical examinations conducted the follow-up telephone consultations.

All participating nurses were female RNs (three Caucasian and one African American). A total of 12 imputed risk and protective factors were addressed during the health consultation. Simultaneously, 10 prevention postcards were mailed twice weekly to parents/guardians asking them to take a few minutes to read and talk about the important key fact found on the card to help their child stay away from alcohol. Each postcard identified a new key fact addressing the same twelve risk and protective factors found in the health consultations. For example, the key fact message for the factor of expectations was worded: "Tell your child that you would be very upset if he/she drank alcohol. Research shows that most kids do NOT like their friends to drink alcohol either!"

Significant differences were found among the three participating schools on age, ethnicity, father's education, and lifetime smokeless tobacco use. The urban school had more non-white students, younger students, more graduate/professional college educated fathers, and fewer students ever using smokeless tobacco than the suburban and rural schools.

Athletes, when compared to nonathletes, are at increased risk for using alcohol, smokeless tobacco, steroids, and marijuana.

Significant differences were also found between urban school youth intervention and control groups on baseline measures of drinking during the last year and intentions to drink in the next year. At baseline, greater numbers of urban intervention students reported having drunk alcohol during the past year and had intentions to drink in the next year compared to control students. No differences were found between groups within the suburban and rural schools on baseline demographic and alcohol use measures.

Results

At post-test, few suburban youth receiving the intervention intended to use alcohol during the next 6 months compared to control youth (see Table 2.1). In addition, fewer rural youth receiving the intervention had used alcohol during the past 30 days compared to control youth. No differences were found on any of the four alcohol use measures between groups for the urban sample.

The suburban and rural school samples were joined for analysis because of their similarities and small number of subjects from each school. Results showed that youth receiving the intervention had significantly lower alcohol use on three of four alcohol consumption measures compared to control youth. Fewer intervention youth (5.5%) than control youth (19.2%) intended to use alcohol during the next 6 months. Fewer intervention youth (3.6%) than control youth (17.3%) drank during the past

Table 2.1
Percentage of Students Using Alcohol at Post-Test by School and Group

	School					
	Urban (n=56)		Suburban (n=66)		Rural (n=41)	
Measure	Intervention	Control	Intervention	Control	Intervention	Control
Intentions to drink during the next 6 months	10.3	11.1	0.0	18.8**	14.3	20.0
Drank during past 7 days	6.9	3.7	5.9	3.1	0.0	5.0
Drank during past 30 days	13.8	7.4	5.9	15.6	0.0	20.0*
Drank "heavily" during past 30 days	6.9	0.0	0.0	9.4	0.0	10.0

* p= 04; ** p= 01

30 days. In addition, fewer intervention youth (0.0%) than control youth (9.6%) drank heavily during the past 30 days.

Discussion

Results from this pilot study suggest that the intervention can be feasibly implemented within the constraints of typical sports physicals, namely the logistical barriers of limited time and staff necessary for providing individual health consultations to large numbers of youth congregated for prescheduled sports physical exams. In addition, this study's findings suggest that brief telephone consultations with a nurse, along with parent print information, appears to have significantly reduced intentions to drink, current alcohol use, and "heavy" consumption among some school athletes six months after their intervention was implemented. In particular, reductions in alcohol use were found for young athletes in suburban and rural schools but not urban school youth.

This study was limited to a small sample of junior high school youth, limiting both the statistical power of the analyses and the generalizability of the findings. In addition, since baseline differences were found between intervention and control groups within the urban school sample, it is not clear if the intervention was less effective for urban youth than suburban and rural students, or if these differential intervention effects were due to pretest group differences within the urban sample.

Combined, these findings indicate that a modified version of the STARS for Families intervention holds promise as a potentially effective preventive approach for reaching school athletes who may be at greater risk for alcohol and other drug use than nonathletes. Cost of the program was estimated at $16.13 per student including the nurse's salaries, and postcard printing, and mailing costs. If additional research supports this study's findings, brief prevention strategies may provide a feasible, cost-effective alternative to more extensive school-based curriculum approaches for preventing alcohol misuse among adolescents participating in school sports programs.

Unresolved issues related to this intervention include: 1) examining the potential role of coaching staff in the program, including recruiting and maintaining young athletes' participation in the program, and reinforcing prevention messages; 2) overcoming or minimizing the limitations of using telephones to provide intervention, including contacting those youth who may be highly mobile, and providing confidential health information into the home; and 3) examining the mechanisms for disseminating and sustaining the intervention across the various school and clinic settings in which youth receive sports physical examinations.

Chudley E. Werch, Ph.D., is a Research Professor, Joan M. Carlson, M.S.W., is a Research Associate, Deborah M. Pappas, M.S.H., is a Research Associate, and Patricia S. Edgemon, M.S.H., is a Graduate Research Assistant, all for the Center for Drug Prevention Research within the College of Health at the University of North Florida. Carlo C. DiClemente, Ph.D., is a Professor and Chair of the Psychology Department at the University of Maryland. This research was supported by a grant from the National Institute on Alcohol Abuse and Alcoholism (Grant No. AA9283).

This article is condensed from C.E. Werch, J.M. Carlson, D.M. Pappas, P. Edgemon, and C.C. DiClemente (2000). Effects of a Brief Alcohol Preventive Intervention for Youth Attending School Sports Physical Examinations. *Substance Use and Misuse*, 35(3), 421-432. It appears here courtesy of Marcel Dekker, Inc., N.Y.

WEB RESOURCES

Center for Enforcing Underage Drinking Laws
www.udetc.org

The Center for Enforcing Underage Drinking Laws is a project of the Pacific Institute for Research and Evaluation. With funding from the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP) they provide training, technical assistance, and resource materials to the States. This Web site includes a number of publications which might be useful, including "Regulatory Strategies for Preventing Youth Access to Alcohol: Best Practices" and "Guide to Conducting Youth Surveys." Also included on this Web site is a listing of the OJJDP contacts in each state.

Focus Adolescent Services: Alcohol and Teen Drinking
www.focusas.com/Alcohol.html

According to their Web page, "Focus Adolescent Services is an Internet clearinghouse of information and resources to help and support families with troubled and at-risk teens." With a mission to provide information and resources to empower individuals through education, self-awareness, self-help, and personal responsibility, this site includes a wealth of information, not just for families but for youth workers as well. This site is truly a clearinghouse, the information found here is composed entirely of links to outside sources, however those links are arranged in an easy to use format and include brief descriptions of what you'll find on the other end. The Focus Adolescent Services Web site is an excellent starting point for finding information on teens and alcohol.

Students Against Destructive Decisions
www.saddonline.com

Students Against Destructive Decisions (SADD) is a school-based organization. Its mission is to "provide students with the best prevention and intervention tools possible to deal with the issues of underage drinking, other drug use, impaired driving, and other destructive decisions." This site contains all information needed to register and run a chapter, lots of different ideas for SADD activities, past newsletters, and contact information for state coordinators.

Family, Religious, School, and Peer Influences on Adolescent Alcohol Use

By W. Alex Mason, Ph.D., and Michael Windle, Ph.D.

The family plays a primary socializing role in the lives of boys and girls. The quality of relationships within the family is a particularly important element in the development of adolescent behaviors. A great deal of research demonstrates that family interactions characterized by parental nurturance, warmth, and social support reduce adolescents' risk for involvement in a variety of problem behaviors, including alcohol use and abuse. Of course there are other important socializing influences during adolescence. Peer relationships, in particular, become more influential during this developmental period, and peers can have a potent impact on the alcohol use of teens. The influence of the school is important as well. An individual's response to the socializing influence of the school has important consequences for the development of problem behaviors in adolescence. Attitudes and behaviors that reflect low commitment to school (e.g., academic failure, dislike for school, low educational aspirations) can increase the likelihood that an adolescent will initiate and maintain the use of alcohol. Also, investigators have recognized increasingly that religion can have an impact on the attitudes and behaviors of youth. A sense of religious commitment and sentiment (often referred to more generally as religiosity) is associated with decreased risk for alcohol use among adolescents.

Few studies of adolescent alcohol use have examined simultaneously the complex relationships that exist among family, religious, school, and peer influences. Toward this end, one goal of this study was to develop a better understanding of the ways in which the family affects alcohol use among youth. In addition to direct effects, the family may have indirect effects on adolescent alcohol use through the secondary socializing influences of peers, school, and religion. For example, boys and girls who have close and supportive relationships within the family may tend to associate with non-drinking peers, which may decrease their risk for alcohol use. Whether the effect is direct or indirect, it is evident that family relationships influence adolescent alcohol use. However, it is also likely that alcohol use among youth affects (i.e., diminishes) the quality of family interactions. Drinking may also result in increased association with alcohol-using peers, as well as decreased academic performance and religiosity. A second goal of this study was to examine possible feedback or reciprocal effects of adolescent alcohol use on the family and on the socializing influences of peers, school, and religion.

Method

We analyzed longitudinal survey data collected from 840 mid-adolescent boys (n = 443) and girls (n = 397) attending a large, suburban (non-parochial) school district in western New York. Beginning in the fall of the 1988–1989 academic year, data were collected using a four-wave design with 6-month intervals between surveys. The average age at the first wave of data collection was 15.5 years. The sample was predominantly white (98.5%) and middle class, and the majority (74%) of participants were Catholic. Adolescents provided information about their own alcohol use, as well as about the alcohol use of their close friends. The surveys also included a self-report measure of family social support and questions regarding school performance (i.e., grade point average) and religiosity (i.e., importance of religion and frequency of church attendance). The content of the surveys varied somewhat at each of the four waves of data collection. In this study, family social support was measured at Times 1 and 3, and all other variables were measured at Times 2 and 4. We tested the plausibility of a model that hypothesized that family social support would be related to later adolescent alcohol use both directly and indirectly, through the peer, school, and religion variables (first aim of the study). The model also hypothesized that adolescent alcohol use would be related, in turn, to later family social support, as well as to later religiosity, peer alcohol use, and school grades (second aim of the study).

Results

Results showed that the hypothesized model was plausible. Figure 3.1 presents a diagram of the statistically significant paths. The coefficients reported in the figure are standardized and can range from −1.0 to 1.0. Values close to −1.0 indicate a strong negative relationship between variables, values close to 1.0 indicate a strong positive relationship; and values close to zero indicate a weak or nonexistent relationship. As the figure illustrates, family social support measured at Time 1 was associated positively with religiosity and school grades at Time 2, and negatively with peer and adolescent alcohol use at Time 2. The associations among these variables were moderate in strength.

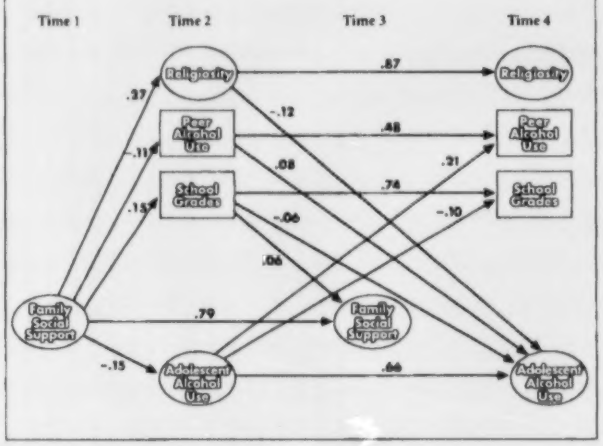
Family interactions characterized by parental nurturance, warmth, and social support reduce adolescents' risk for involvement in a variety of problem behaviors, including alcohol use and abuse.

Each of the Time 2 variables was associated, in turn, with self-reported adolescent alcohol use at Time 4. The significant positive path leading from Time 2 to Time 4 adolescent alcohol use indicates that alcohol use was relatively stable over time; an adolescent who reported a high level of alcohol use at Time 2 tended to report a high level of alcohol use at Time 4, relative to other adolescents in the study. Among the remaining Time 2 variables, religiosity was the strongest predictor of Time 4 alcohol use. The negative value of this path estimate indicates that a high level of religiosity was associated with less alcohol use over time. Better school grades at Time 2 were associated also with less alcohol use at Time 4. Having close friends who drink alcohol was associated with more alcohol use over time.

Adolescents who reported a high level of family social support at Time 1 also tended to report a high level of family social support at Time 3. School grades measured at Time 2 were associated with family social support measured at Time 3. More specifically, better school grades predicted an increase in family social support; however, this was not a strong relationship.

We also examined the effects of alcohol use measured at Time 2 on religiosity, school grades, and peer alcohol use measured at Time 4. Alcohol use at Time 2 predicted an increase in association

FIGURE 3.1



with peers who use alcohol and a decrease in school grades over time. Contrary to expectations, adolescent alcohol use measured at Time 2 was not associated with a reduction in religiosity at Time 4, nor was it associated with a reduction in family social support at Time 3.

Discussion

This study demonstrates that the family, the school, religion, and peers play prominent roles in the alcohol use of adolescent boys and girls. The influence of the family was both direct and indirect. We found that perceived family social support at Time 1 had a direct, negative association with adolescent alcohol use at Time 2. Family social support predicted lower levels of alcohol use among the participants over time. In addition, family social support at Time 1 indirectly predicted reduced adolescent alcohol use at Time 4 through the religion, school, and peer variables.

The family, the school, religion, and peers play prominent roles in the alcohol use of adolescent boys and girls.

Interestingly, religion was especially important in the link between family social support and adolescent alcohol use. Boys and girls who reported having emotionally close and supportive families were more likely to be religiously committed over time than youth from less supportive families. Furthermore, religiosity was associated with reductions in adolescent alcohol use. These findings indicate that the family provides an important social context for the development of adolescent religiosity and that religious commitment, in turn, reduces risk for alcohol use among teens.

Findings indicated also that family socialization is related to adolescent alcohol use, in part, through a process of peer selection. We found that family social support was directly and negatively related to peer alcohol use. Mid-adolescent boys and girls from supportive families tended to associate with non-alcohol-using peers. In turn, such associations reduced alcohol use during late adolescence. In addition to the effects of peer alcohol use on adolescent alcohol use, we found that drinking was positively related to association with alcohol-using peers. This finding indicates that peer and adolescent alcohol use may be related reciprocally: teens who drink alcohol tend to increase their associations with peers who drink, which, in turn, tends to increase their own alcohol use.

The measure of school grades also played an important role in linking family social support with adolescent alcohol use. A high level of perceived family social support was associated over time with self-reports of better grades; in turn, better grades were associated with reduced alcohol consumption. In addition to the effects of school grades on adolescent drinking, we found that alcohol use was associated with lower school grades over time. Taken together, these findings suggest a process in which low school performance increases risk for alcohol use which, in turn, decreases school performance.

It is important to note that participants in this study were predominantly white, middle class, and Catholic. Thus, additional studies are needed to determine whether or not the current findings generalize to adolescents of varying racial and ethnic backgrounds, as well as to boys and girls affiliated with other religions traditions. Nevertheless, this study contributes to the literature by examining the complex relationships that exist among family, religious, school, and peer influences on adolescent alcohol use. The findings have implications for the development of effective preventive interventions by suggesting that programs should be multifaceted and targeted at multiple domains of influence in adolescents' lives. In this regard, family-based programs that incorporate intervention components focused on peers and schools may offer the most promise. Such programs would benefit as well from a consideration of the value that many adolescents and their families place on religion and spirituality. As a whole, the findings of this study illustrate the importance of moving beyond the mere identification of risk and protective factors for adolescent alcohol use to a deeper understanding of the processes or mechanisms through which such factors have their effects.

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The members of *The Prevention Researcher*'s Editorial Board are invaluable resources. Through their input we are able to bring to our readers the best research-based articles possible. We would like to extend out heartfelt thanks to the following Editorial Board members who have just completed nine years of service to *The Prevention Researcher*:

- J. Robert Lilly, Ph.D., a Regents' Professor of Sociology at Northern Kentucky University and a visiting professor of sociology at the University of Durham, Durham, England;
- Jim McKnight, Ph.D., president of the National Public Service Research Institute in Landover, Maryland; and
- Stuart Schweitzer, Ph.D., a health economist and professor of health services at the UCLA School of Public Health.

We would also like to welcome the following new members to our board:

- Audrey Block, J.D., M.S.W., Senior Research Associate at RMC Research Corporation, Portland, Oregon;
- Michael C. Miller, M.D., Assistant Professor of Psychiatry at Harvard Medical School; and
- Drew Velting, Ph.D., Assistant Professor of Clinical Psychology at Columbia University.

Preventing Underage Alcohol Access: Policy and Enforcement

By Kathryn Stewart, M.S.

One of the major challenges faced by states and communities is the prevention of underage alcohol access. Underage drinking is widespread and, to a large extent, tolerated by society. It is also implicated in a range of health and social problems that are both tragic and costly. There are good reasons for a high level of concern about underage drinking:

- Alcohol is the drug most commonly used by youth—more than tobacco and far more than marijuana or any other illicit drug.
- Alcohol is one of the most common contributors to injury, death, and criminal behavior among young people.
- In addition to the immediate and potentially tragic consequences of underage drinking, early onset of alcohol use increases the risk for chronic alcohol addiction.

The bad news is clear and all too visible. Underage alcohol use is a serious problem. But fortunately there is good news as well: a variety of effective strategies have been developed to reduce underage drinking. These strategies can be applied in all sectors of the nation, state, and community —in all areas of the systems that produce, distribute, promote, and consume alcohol. Preventing underage drinking saves lives and saves futures.

Overview

This article will outline some of the most important strategies that can be employed by states to reduce youth access to alcohol as well as some of the ways that agencies can work together in broad efforts to reduce underage drinking. While the strategies described are usually applied at the state level, many of them can also be used by communities.

The strategies outlined will draw upon the combined power of sound laws and policies, vigorous deterrence, and strong public support. Each of these elements is important individually and can make a difference in preventing underage drinking. But the elements multiply their effectiveness when they are coordinated. Coordinated efforts can ensure that laws are well designed, based on sound principles of deterrence, easy to enforce, and supported by the public. Vigorous enforcement of the laws, when supported by the public, can enhance the laws' deterrence effects and bring about a normative change in the community so that underage drinking and providing alcohol to minors are no longer socially accepted. The public can help bring about enactment of effective laws and policies, as well as effective enforcement, through exerting its influence and demonstrating its concern. When this happens, policy-makers feel supported in enacting appropriate laws, enforcement agencies feel that their efforts are endorsed by the community and likely to be carried through by the judicial system, and the public is empowered to establish a healthier social environment.

The Results of Age 21 Laws

Despite concerns about continued drinking by youth, it is important to remember that raising the minimum drinking age has been very successful in reducing alcohol related problems among youth. There is strong research evidence that establishment of 21 as the uniform minimum drinking age for alcohol has reduced alcohol-related automobile crashes among young people. While all alcohol-related traffic fatalities have declined in recent years, fatalities in which the driver was under 21 have declined even more dramatically. In fact, the National Highway Traffic Safety Administration estimates that more than 18,000 lives have been saved in traffic crashes since the law was changed. Some research also indicates that raising the drinking age to 21 has significantly reduced deaths due to suicide, unintentional injuries, and youth homicide.

Raising the drinking age seems to reduce the amount of drinking and alcohol problems even after young people reach the age of 21. That is, there does not seem to be any rebound effect once legal age is achieved.

Obviously, many young people still drink despite the law and many suffer negative consequences as a result. Concern about youth drinking should result in redoubled efforts to make minimum purchase age laws work even better. Policies should be refined and enforcement applied more vigorously. Better implementation of minimum purchase age laws should be a priority for policy makers and others concerned about underage drinking.

Underage drinking is widespread and, to a large extent, tolerated by society.

Consumption Patterns of Underage Drinkers

One reason that preventing underage drinking is so important is that young people have particularly risky drinking patterns. When they drink, they are likely to drink large quantities. Figure 4.1 provides some information about drinking patterns among youth.

According to Monitoring the Future, the annual school survey of youth, most young people do not drink, or at least don't drink regularly. The majority of eighth and tenth graders did not drink alcohol in the last 30 days and about half of twelfth graders did not drink. While these figures are reassuring in that most young people are not regular drinkers, a significant minority not only drinks but also drinks heavily. In fact, among those young people who drink, most are binge drinkers.

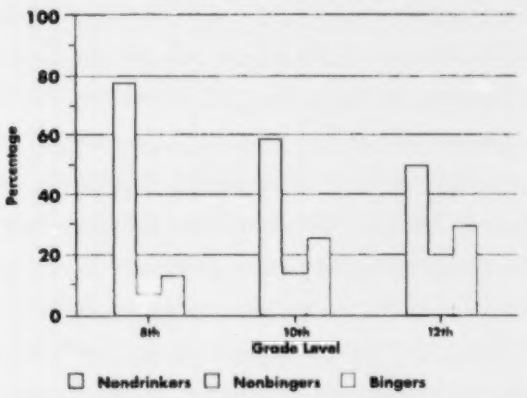
Environmental Strategies

This article will focus on the strategies that can be used to help create healthier state and community alcohol environments. For many years prevention efforts have focused on strengthening individual children. This is often done through school programs and other venues to educate young people about the consequences of drinking or to teach skills, such as how to refuse an offer of a drink. Some strategies have also tried to make young people more sophisticated about marketing so that they can resist the allure of alcohol as it is depicted in advertising and popular culture. These strategies are worthwhile, but do not address the environments in which young people live and learn.

Environmental strategies create environments in which the opportunities to drink are fewer and the temptations weaker. When these strategies are implemented, alcohol is made less available to young people, it is promoted in ways that are less

FIGURE 4.1

30-Day Drinking Patterns by Grade



Source: Johnston, L.D., O'Malley, P.M., and Bachman, J.G. (2001). *Monitoring the Future National Survey Results on Drug Use, 1975–2000. Volume I: Secondary School Students* (NIH Publication 01-4924). Bethesda, MD: NIDA.

likely to be seen by young people and to be appealing to them, and the consequences of illegal sales and use are made clear and compelling.

Because alcohol is a legal product and its sale is regulated, there is a wide range of policies that can be imposed at the state and local level to discourage alcohol use by minors. The remainder of this paper will present the essential elements of alcohol policy that should be included in the legal framework in each state to reduce underage drinking as well as the essential elements of enforcement to implement these policies effectively. Some of the strategies discussed below are well supported by research and evaluation. Others have not been studied but are promising based on established prevention principles.

Essential Elements of Alcohol Policy: The Legal Framework

States control various aspects of the system by which alcohol is marketed, sold, purchased, and consumed. Each element of the system provides opportunities for creating a healthier alcohol environment. Local governments can also implement controls to supplement state laws.

The discussion of the legal framework will include minimum purchase age laws and policies aimed at youth, retailers, other adult providers, and at the availability of alcohol in general.

Policies Aimed at Youth

Every state prohibits sales of alcohol to minors, but the nature of these laws and the associated policies varies in ways that make the laws more or less effective. Following is a discussion of some of the key issues that states should consider in reviewing their existing laws and policies. Some of these specific strategies have not been evaluated with regard to their effects on underage drinking. They are considered important in establishing consistency and fairness in the laws.

• **Definition of "minor in possession":** The way in which minor possession of alcohol is defined in the law or in practice can have a major impact on the difficulty of enforcement of these laws. In some states, minors are considered to be in possession only if they are actually holding the alcohol. In such circumstances, it is easy for the minor to evade consequences.

• **Laws concerning minor attempts to purchase alcohol:** Most states have laws that prohibit minors from attempting to purchase alcohol. Some states, however, lack these laws or have laws that are weak and difficult to enforce. In these situations, the entire burden of illegal sales falls on the retailers while minors are free to continue shopping from outlet to outlet until they have been successful in purchasing alcohol. Strengthening these laws can help limit sales to minors.

• **Exceptions to "minor in possession" laws:** Some states include major exceptions to minor in possession laws, including permitting parents to serve alcohol to their own children and permitting minors accompanied by parents or spouses in licensed premises where they would otherwise be prohibited. No state wishes to interfere unnecessarily with the authority of parents over their children, but such exceptions to underage drinking laws are sometimes viewed as weakening the general message prohibiting underage drinking. They can also make enforcement of underage drinking laws more difficult.

Policies Aimed at Retailers

Laws and policies aimed at retailers are at the heart of any effort to reduce underage drinking. While young people obtain alcohol from a variety of sources, as long as they can buy it easily at retail outlets, other attempts to reduce underage drinking are likely to fail. All states prohibit the sale of alcohol to minors and, as will be discussed, vigorous enforcement of these laws is essential. As has been established by some evaluation studies, the adoption of good policies in support of laws regarding sales to minors can affect the extent to which youth have access to alcohol. Policies aimed at retailers include:

• **Minimum age and supervision for sellers of alcohol:** In some states, even though the drinking age is 21, youth below the drinking age are still able to sell alcohol. Laws also vary regarding the level of supervision that underage sellers must have. Research indicates that underage sellers and servers have a harder time refusing sales to underage buyers and are more likely to misjudge the customer's age, make exceptions for friends, and respond to peer pressure.

Among those young people who drink, most are binge drinkers.

A recent national survey found that nearly 80 percent of respondents favor laws that require that all servers and sellers be at least 21 years old. Nonetheless, economic interests often make changing the limit difficult.

• **Education and training of sellers and servers:** Sellers and servers of alcohol can be more cooperative and effective in reducing underage drinking if they are well informed about their responsibilities, the importance of adherence to the law, potential consequences for violation of the law, and the skills and techniques they need for avoiding sales to minors. There is considerable evidence that responsible beverage service training reduces intoxication and impaired driving. There is less evidence for an effect on sales to minors; however, it is only fair to make sure that sellers and servers have the knowledge and skills they need before holding them responsible for adhering to the law.

• **Penalties for sales to minors:** The violation of laws against sales to minors can lead to both administrative and criminal penalties. Administrative penalties affect the retailer's state and/or local operating license. Criminal penalties are levied against the individual committing the violation and may include fines and imprisonment. Most experts recommend an emphasis on administrative penalties for a number of reasons,

including their swiftness and certainty and the fact that they hold the licensee responsible rather than the clerk, who may be young, inexperienced, poorly trained, poorly paid, and poorly supervised. The licensee rather than the clerk is in the best position to prevent future violations.

To be effective, administrative penalties should impose real costs on the violator, with increases in severity for repeat offenses. While penalties should be significant, it is important that they not be too severe, especially for first offenses. Law enforcement and licensing officials are less likely to impose penalties if the punishment is perceived as out of proportion to the seriousness of the offense.

Policies Aimed at Other Adult Providers

Regulating retail availability is central to reducing youth access to alcohol. If this relatively simple source of alcohol is not removed, no other strategies can be effective. Research shows, however, that young people obtain alcohol from a variety of sources, including older friends, strangers who purchase for them as a favor or for a fee and even parents or other relatives. Reducing these sources of alcohol is more difficult and complex and requires a multifaceted approach designed to deter the illegal behavior of adult providers and change community norms. Little research has been carried out in this area, but it is likely that improvements in the legal framework can help to decrease this source of alcohol for minors.

Environmental strategies create environments in which the opportunities to drink are fewer and the temptations weaker.

• **Laws against adult provision:** All states restrict a minor's ability to obtain alcohol through noncommercial sources, although, as discussed above, most statutes provide exceptions, particularly for parents, spouses, and guardians. The President's Commission on Model State Drug Laws, however, recommends against these exceptions because it "sends mixed and confusing signals to parents and youths alike that underage drinking is tolerable under certain circumstances."

• **Keg registration:** Beer kegs are a popular source of alcohol at teen parties. Kegs provide a cheap, convenient source of alcohol and are often purchased by a friend or relative over 21. Keg registration regulations reduce the availability of this form of alcohol to underage drinkers. They require retailers to identify kegs with a tag, sticker, or other form of identification. At purchase, the retailer requires a deposit and records the purchaser's name, address, and other identifying information. If law enforcement personnel confiscate a keg at a teen party, they can easily trace the purchaser and impose sanctions. Keg registration laws have not been well evaluated and little empirical data exists, but some states report a dramatic decrease in the sale of kegs following their adoption.

• **Teen party ordinances:** Teen parties are one of the highest risk settings for underage drinking. Young people report their heaviest drinking at large parties with peers, most of whom are underage, in private homes. Despite the seriousness of the potential problems, communities tend to be tolerant of these parties and this tolerance is compounded by legal obstacles to law enforcement. Police detecting a teen party may not have legal grounds to enter the premises, be unable to confiscate the alcohol, trace its original purchase, or hold the adult householder responsible for allowing the party on the premises. Some communities are experimenting with ordinances to address these problems. The effectiveness of these ordinances has not yet been evaluated so reliable data does not presently exist.

Policies Aimed at Alcohol Availability in General

A large body of research establishes that when stronger controls are placed on alcohol availability, drinking is reduced and fewer alcohol-related problems occur. This principle applies to underage drinkers as well as to the population as a whole. Alcohol regulations that control availability in general can have an important impact on underage drinkers. Key availability controls and their applicability to underage drinkers are discussed briefly below.

• **Price:** The price of alcohol is regulated at the state level in part through taxation and in part through controls on price promotions (such as all-you-can-drink or two-for-one specials at bars). Young people are particularly sensitive to price, and research shows that even modest price increases can significantly reduce the rates of heavy drinking, thus reducing impaired driving crashes involving youth.

• **Controls on density and location of outlets:** Restricting the density or location of alcohol outlets is one way of reducing alcohol-related problems. A large number of outlets per capita or per square mile and the over-concentration of outlets in a given location are associated with increases in alcohol-related traffic crashes as well as youth violence.

• **Controls on sales in public places:** Alcohol sales at community events create a high risk for underage drinking and related problems. States and local jurisdictions have taken various steps to reduce these risks, including restricting the issuance of licenses at youth-oriented and family-oriented events and requiring responsible beverage service management policies and training.

Restrictions can also be placed on the availability and consumption of alcohol in parks, recreational facilities, beaches, and other unsupervised locations that are either publicly owned or open to the public. Such places are often the venues for teen drinking parties. Controls can also be placed on alcohol service at organized private gatherings such as weddings, large picnics, etc.

• **Controls on advertising and promotion:** Research on the role of alcohol advertising and promotion indicates that young people who have had the most exposure to advertising have more positive attitudes toward drinking and are more likely to become drinkers. The research on the effects of controls on advertising is less clear, but many researchers and policy makers agree that controls on advertising and promotion can change the normative environment. For example, some communities have refused to allow alcohol sponsorship of community events. Some states have placed limitations on outdoor advertising of alcohol, including advertisements in alcohol outlets that are visible from the street.

Laws and Policies Regarding Identification

As discussed above, underage drinkers can be creative and persistent in their efforts to obtain alcohol. Many young people use false identification to purchase alcohol. A recent survey found that 36% of the underage high school and college student respondents carry false identification, 14% had used someone else's identification, and 12% had altered the birthdate or picture on a valid identification. Young people can easily obtain

false identification from many sources, including a host of Internet sites offering false identification as a "novelty" item. Interestingly, despite the prevalence of false identification, young people report that they use them infrequently to purchase alcohol, most likely because they are able to obtain alcohol through various other means without using identification. As enforcement of laws against sales to minors becomes more vigorous, however, use of false identification may become more frequent.

The design of identification cards can help to mitigate the problem of false identification. Many states now make the identification of minors distinctly different from that of adults so that the birth date cannot easily be altered and so that sellers of alcohol need not calculate age. In addition, some states now use identification cards with key information (name, birth date, address, etc.) encoded so that it can be read with special equipment. Such a system should be no more difficult or expensive to install and use than the ubiquitous card readers for credit cards.

Essential Elements of Alcohol Enforcement: Creating Credible Deterrence

Some laws and policies can have an impact with only minimal attention to implementation and enforcement. Tax increases, for example, once imposed, have their effect without continuous monitoring or attention. Most laws and policies, however, require some level of enforcement to be optimally effective. The most important effect of enforcement is to deter illegal behavior. It is impossible to apprehend and punish most violators of laws. Rather, the key goal of enforcement is to create a credible threat of apprehension and punishment that prevents people from violating the law.

Research shows that young people obtain alcohol from a variety of sources.

While enforcement is a key component of deterrence, it is not the only component. Maximum deterrence is usually found to occur when potential violators perceive that they are very likely to be caught, and that they are likely to receive a significant penalty very quickly. As long as the punishment is significant, its severity is not as important as its certainty and swiftness. Enforcement agencies can help ensure optimum deterrence by carrying out vigorous, well-publicized campaigns. In order to guarantee optimum deterrence, however, the courts or other agencies involved in imposing penalties must also work efficiently and effectively.

When planning enforcement strategies, it is important to remember that *underage drinking is fundamentally a problem with the behavior of adults.* While young people may ultimately consume alcohol illegally, they do not manufacture, promote, or market it. In any underage drinking episode, somewhere along the line an adult has violated the law or failed to exercise due care. Minors should be held accountable for their illegal actions, however, the bulk of enforcement efforts should be aimed at adults. In general, the most effective and efficient strategies are those aimed at retailers who are, after all, licensed to provide alcohol in a responsible manner. Despite this fact, research shows that the vast bulk of underage drinking law enforcement action is taken against underage purchasers rather than sellers.

While young people have a variety of ways of obtaining alcohol, no other enforcement effort can possibly cut off access to alcohol unless there is enforcement that makes it difficult for them to simply walk into an outlet and buy a six-pack. A comprehensive enforcement program should also include other strategies, but retail enforcement, usually in the form of compliance checks, is key to the success of any program.

Conclusions

Underage drinking is a serious problem that has enormous economic and human costs. It is a problem, however, in which we have made significant progress. A range of effective strategies has been developed to reduce underage drinking. Applying these strategies requires us to overcome challenges and make difficult choices. But the payoff is measured in lives and futures saved. States and communities can provide leadership in this effort; they can supply the enforcement muscle that is needed to maintain the gains we have made; they can implement comprehensive approaches to preventing underage drinking that will enable us to make further progress. ⇢

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UPCOMING TOPICS

Juvenile Sex Offenders.

Studies of adult sex offenders suggest that many of them began their sexually abusive behavior in their youth. The youth who commit sexual offenses are very heterogeneous, as are the acts they perpetrate. While many prevention programs have focused on educating potential victims, very little has been done to prevent youth from offending in the first place. Our November issue will look at the characteristics of adolescent sex offenders and current strategies for preventing youth from sexually offending.

Resource Issue.

This year's Resource Issue (which is only available to subscribers) will include an interview with Dr. Randa Ryan, from the University of Texas, Austin, regarding athletes and eating disorders. Caitlin Ryan, M.S.W., from the Institute on Sexuality, Inequality, and Health, at San Francisco State University, will be participating in our Q & A regarding lesbian and gay youth. This issue will also include a number of Web site reviews, book reviews, and free resources available on the Internet. The 2002 resource issue will be available at the end of December.

Resiliency.

Originally a concept developed in the 1950s, resiliency refers to the ability of most youth to thrive despite adverse life circumstances. Volume 10(1) of *The Prevention Researcher* looks at the concept of resiliency and the differences between risk and protective factors. This issue will look at the role of resiliency in violent behavior, how resiliency may be different for African American youth, and ways that service providers can incorporate resiliency into their work with youth. Volume 10(1) will be mailed to subscribers early February, 2003.

Other future issues include Post-Traumatic Stress Disorder, Teen Parents, and Youth as Resources.

Community Action to Reduce High School Adolescent Alcohol Use

By Cheryl L. Perry, Ph.D., Carolyn L. Williams, Ph.D., Kelli A. Komro, Ph.D., and Sara Veblen-Mortenson, MPH, MSW

Alcohol use is most problematic during high school and early adulthood. The most prevalent causes of death and disability among adolescents involve alcohol in notable proportions, including deaths due to motor vehicle crashes, homicides, and suicides. In addition, alcohol use takes on additional meaning for older adolescents, since drinking increasingly co-occurs with driving, dating, and social events. Unfortunately, very few alcohol use prevention programs have been developed or evaluated for high school students.

Project Northland is among the latest generation of comprehensive community trials focusing on the prevention of alcohol-related problems using multiple interventions. This new generation combines individual behavior change strategies, primarily focusing on demand reduction, with social-environmental approaches targeting supply reduction and normative change. These population-based programs recognize the prevention paradox: Even though problem drinkers face the greatest personal risk from excessive drinking, the majority of individuals who experience problems related to alcohol use (e.g., assaults, motor vehicle crashes) are light or moderate drinkers.

The most prevalent causes of death and disability among adolescents involve alcohol in notable proportions.

Project Northland was designed to delay onset of underage drinking and reduce alcohol use by adolescents. The cohort for this study included all sixth grade students (N= 2,351) enrolled in 24 public school districts at baseline (1991), and who were present at follow-up. School districts were randomly assigned to intervention or control conditions. These schools are in six northeastern Minnesota counties with very high rates of alcohol-related problems. Intervention materials from Phase I, for the sixth to eighth graders, are now being disseminated by Hazelden Publishing.

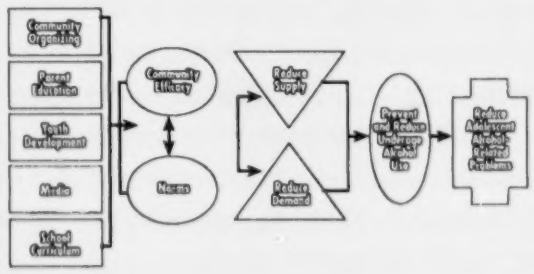
Similar to other successful prevention programs, the positive outcomes of Phase I attenuated. At the end of tenth grade, there were no significant differences between student alcohol use in the intervention and reference communities. Alcohol use may be more resistant to long-term change than cigarette or marijuana use, perhaps because consistent, clear, and compelling messages to discourage underage drinking are not provided by American society. Phase II of Project Northland builds on the early adolescent interventions with new strategies for the cohort's last years in high school while emphasizing changes in the social environment of young people. Phase II's intervention goals are to increase community efficacy to enact change and to improve community norms around high school students' alcohol use.

Phase II Interventions

Interventions for Phase II were guided by the behavioral model shown in Figure 5.1, which emphasizes changes in social-environmental factors (particularly norms, role models, opportunities, and social support) and personal factors (such as self-efficacy). Five Phase II intervention strategies — community organizing, parent education, youth development, media, school curriculum — were each designed to make changes in these factors. Table 5.1 lists the specific norms targeted. The emphasis on normative change comes from the prevention research literature, which suggests that even in "skills development" interventions, shifts in perceived norms account for observed changes in adolescent behavior. In addition, Phase I demonstrated that community-level norms accounted for 33% to 38% of the variance in adolescent alcohol use. Because norms appear to be established at the community level, as well as within schools and families, interventions were designed to reinforce these norms within classrooms, families, schools, and the larger community.

FIGURE 5.1

Behavioral Model to Guide Intervention Development for the High School Phase of Project Northland



The five intervention strategies were also designed to increase community efficacy to enact changes in policies and practices related to high school students' alcohol use. Community efficacy refers to the level of confidence that community members have in collectively taking action and creating change in their communities. Community efficacy reflects increased skills in facilitating community change over the course of the intervention. It is not an indication of past achievements, cohesion, or readiness, which have been used as indicators in other community projects.

The five strategies were chosen based on prior research. For the most part, the conceptualization of the strategies and the process of implementation were done by Project Northland staff; the choice of projects and activities that would be the focus of community action was done by community members.

Community Organizing

In Phase I, there were no detectable community-level outcomes such as reductions in the ability of young people to purchase alcohol. Given our intervention model, which emphasizes changes in norms and community efficacy, we decided that citizen involvement and community-level change needed to be the centerpiece of our interventions during Phase II. Community-level changes are particularly important to reinforce and sustain

Table 5.1 Normative Expectations

1. It is unacceptable for high school students to drink.
2. It is unacceptable for anyone (for example, parents, older teens, merchants, other adults) to provide alcohol to high school students.
3. Adults and high school students should take action when high school students are drinking.
4. High school students can have fun, establish their maturity and independence, and relieve stress and boredom without alcohol.
5. Parents have an influence on their high school students' drinking. Parents can provide social support, set clear expectations, monitor and supervise, and avoid inconsistent or excessively severe punishment.
6. Community events and public places are opportunities for modeling healthy behaviors for high school students.

the changes that took place in peer influence, self-efficacy, and parent-child communication in Phase I.

Our Phase I experiences suggested that citizen mobilization in smaller communities was difficult, particularly if actions involved risk or confrontation, even when the community members strongly believed in our goal. Therefore, skill development in direct action strategies was selected as an approach to increase a community's ability and willingness to take action. Direct action community organizing was implemented as a systematic and efficient process to mobilize community members to support, initiate, and establish policies and practices to reduce adolescents' access to alcohol. Table 5.2 (on page 14) indicates the primary community organizing methods implemented during Phase II.

Seven community organizers were selected to implement the direct action organizing. The organizers followed the process outlined below, but the choice of activities was made by community members. The organizers first interviewed citizens with an interest in adolescent alcohol use prevention and/or who represented a broad spectrum of the community. The purpose of these interviews was to identify each community's social, economic, and power structures; determine both the community's and the interviewee's interest in reducing students' access to alcohol; determine how the problem was perceived in the community; and build a broad base of support for future actions.

The second stage involved the recruitment and formation of community action teams. The action team members were recruited based on self-interest in reducing underage access to alcohol, leadership ability, access to resources, and representation of a particular community sector. The teams were intentionally broad based and included members from the education, business, civic, faith, medical, public health, parent, and youth sectors. Regional training for action team members, as well as training for high school athletic directors and coaches, was held to support the work of the local teams.

Teams were encouraged to develop action plans indicating the methods they would use to decrease commercial (liquor stores, bars, convenience stores) and/or social (adults, peers, siblings) availability of alcohol to adolescents. All action teams offered responsible beverage service (RBS) training for bartenders and clerks, and most had similar merchant training for management and owners. These training sessions emphasized appropriate age identification procedures and other actions to decrease commercial availability, and were followed by compliance checks of age-of-sale laws coordinated by the action teams and local law enforcement. Other methods are listed in Table 5.2.

Direct action community organizing was an effective and efficient approach to bring about community-level change, as indicated by the high percentage of action teams that initiated activities that could affect community-level policies and practices. Still, the process is lengthy and requires skilled and dedicated organizers in order to succeed. The organizers needed to be willing to take political risks, oppose people within their own communities if necessary, and be consistently oriented toward community change as the goal of their action groups. Thus, a key lesson learned from Phase II is that to accomplish community-level change, community members need to be well organized, well trained, and intensely focused on bringing about significant change in policies and practices that affect the norms of underage drinking in their communities.

Parent Education and Involvement

Parent involvement was a central feature of Phase I, and we were effective in reaching more than 90% of our cohort's parents. The role of parents for high school students is one in which increasing independence is granted to the adolescent; yet, monitoring and supervision are still needed. Thus, in Phase II, direct education on relevant issues for parents of high school students was the key intervention goal. In addition, parents were encouraged to join community action teams or to participate in their activities.

Even though problem drinkers face the greatest personal risk from excessive drinking, the majority of individuals who experience problems related to alcohol use are light or moderate drinkers.

A postcard campaign was designed to increase awareness about alcohol-related issues and encourage specific actions to keep adolescents alcohol free. Postcards were mailed to the cohort's parents at 6-week intervals and included colorful artwork on one side and a short message with behavioral suggestions on the other. Because they were relatively inexpensive and could be produced quickly, the postcards' themes were tailored to community events and complemented other activities sponsored by the action teams. For example, one card addressed the concern of parents' providing alcohol to their teen. Another card alerted parents to the fact that most of the problems resulting from alcohol use were found among "average" rather than high-risk teens.

A new parent-child intervention was developed for the cohort's senior year, a pseudo-contest called Sound OFF! The purpose of Sound OFF! was to encourage parents and their seniors to communicate about alcohol. The relatively low (20%) response rates highlighted the difficulties of engaging high school seniors in prevention activities with parents, and most likely reflects the increased autonomy of high school students and their unwillingness to talk with their parents about their social world and the social behaviors that are imbedded in the peer group. In addition, by the twelfth grade, nearly all young people have had a drink, and 56% of our cohort had had a drink in the past month, even with parental disapproval, so parent-child communication may be difficult to structure around this topic.

Youth Development

Youth involvement had been a central feature of Phase I, which was a considerable success. In Phase II, youth action teams were formed. Adult part-time coordinators in 18 high schools recruited

Table 5.2 Intervention Components for the High School Phase of Project Northland

Strategy	Participation	Description
Community organizing methods (11 action teams representing 13 communities)		
One-on-one interviews	11/11 teams	Interviews on teen alcohol use conducted by organizers with community members
Formation of action teams	11/11	Teams of community members with a vested interest in decreasing adolescent alcohol use form to take action
Regional training	10/11	Training community action teams
Server training	11/11	Responsible beverage service (RBS) training provided to servers in the community, emphasizing appropriate age identification procedures
Merchant training	8/11	RBS training for managers and owners
Compliance checks	7/11	Checks by young people to determine whether merchants sell to underage
Community festivals	10/11	Participation in fairs and festivals with booths and distributions of petitions, buttons, and brochures
Policy adoption	5/11	Community policies initiated such as "safe houses" and increases in beer license fees
Ordinance adoption	3/11	Community ordinances such as administrative penalties, curfews, mandatory RBS training, and noisy assembly laws implemented
Parental education (parents of the intervention students)		
Postcards	100% parents	11 postcards sent directly to the parents of the study cohort to increase awareness about alcohol-related issues
Sound OFF!	20% parents	Contest to encourage parent-child communication about alcohol
Youth development activities (18 action teams representing 18 schools)		
Summer video project	17/18 teams	Community-specific videos made by students about alcohol use
Regional training	17/18	All-day training programs for youth action team members
Youth Day	9/18	Students testified at the Minnesota legislature concerning a bill to reduce youth access to alcohol
Alcohol-free activities	13/18	Alcohol-free, social events planned by students (such as dances and all-night lock-ins at school)
Homecoming/prom	13/18	Alcohol-free, safe events before and after homecoming, proms, etc.
Community festivals	10/18	Participation in fairs and festivals with booths, floats, etc.
"Chemical health weeks"	8/18	Educational activities during this week such as sponsoring speakers and mock car crashes
Mentoring	5/18	Providing alcohol education or other support to younger students
Policy projects	4/18	Changing community policies such as alcohol at community festivals
Adult action team media projects (13 communities)		
Merchant calendars	9/13	Calendars created for alcohol beverage merchants
Faith organizations	8/13	Educational messages for church bulletins
Print media (18 schools and surrounding communities)		
Media kits	18/18	Media advocacy training and kits for action teams
Newsletters	18/18	Updates on Project Northland activities to action team members and students
Don't Provide	12/18	Print media campaign to not provide alcohol to teens
Celebration poster	18/18	Thank you poster for participants
Classroom curriculum (intervention students)		
Class Action	92% students	Eleventh grade curriculum based on the Mock Trail Program

young people to participate in teams to decrease alcohol use among their peers. The teams met as an extracurricular activity, after school and on weekends, assisted by the coordinators. The coordinators and action team members followed general guidelines for activities for their teams, but the specific activities were selected by each team (see Table 5.2).

Seventeen youth action teams worked on a summer project that involved producing community-specific videos about adolescent alcohol use and its negative consequences. These videos were replayed over the two years of intervention in many community and school gatherings. Other activities included regional training sessions, and a Project Northland Youth Day at the Minnesota State Capitol. These regional events were developed to demonstrate that there was a larger, positive peer group across northeastern Minnesota supporting the norms in Table 5.1.

Planning alcohol-free social events was popular across teams. Other activities included planning safe homecoming, prom, and graduation events; participating in community events such as fairs; developing activities for "chemical health weeks"; mentoring other students; changing policies related to alcohol sales at community festivals; decreasing underage access to alcohol; and/or parents providing safe and alcohol-free homes.

The youth action teams were successful in providing an opportunity for cohort members to create, plan, and implement activities that might influence alcohol-related norms in their communities. However, the members of the teams were a small percentage of the entire intervention cohort. In addition, students preferred concrete, educational activities to those aimed at changing school or community policies. The students who participated were among the more active students in their communities, so scheduling meeting times was problematic for many of the teams. Even with these barriers, the accomplishments of the teams are noteworthy and demonstrate how much positive energy is available for productive youth development among high school students.

Media

The use of radio and television has not been possible in Project Northland due to the proximity of the reference and intervention

communities. Instead, we have relied on print media to "market" messages, advertise events, and support the communities' adult and youth action teams (see Table 5.2).

Youth and adult action team members were trained separately in media advocacy to increase coverage of underage alcohol use at the local level, and media kits were provided to each community team. Action teams were also assisted in developing letters to the editor, flyers, brochures, buttons, signs, and so on. Other media activities included Project Northland newsletters sent to the cohort and members of the action teams, the creation of merchant calendars which assisted clerks in calculating a buyer's age, educational messages sent to religious institutions to include in their bulletins, and the Don't Provide campaign.

The Don't Provide campaign targeted the young adult (18–22 years) population and was designed to reduce social availability by communicating the norm that providing alcohol to adolescents is unacceptable. A series of posters, postcards and Mylar stickers for stores' cooler doors were used and many media articles were written about the campaign. An advertising agency provided the concept, design, and graphic work at no cost and the materials were distributed by community and/or youth teams. The posters and matching postcards had 1950s photographs of young children that had been altered to look as if the children were drinking alcohol. Each poster included a catchy phrase (e.g., "No matter how much they beg, don't buy them a keg!"), a subtheme ("They're just kids, for crying out loud!"), and short messages about the legal consequences of providing.

Direct action community organizing was an effective and efficient approach to bring about community-level change.

The final major media effort was a celebration and thank you poster, "Celebrating Success: How Project Northland Became a Prevention Model for the Nation," which was developed and mailed to approximately 5,500 community members. Eight outstanding Project Northland volunteers representing students, parents, police, schools, or the broader community, were pictured on the poster.

The various media activities during Phase II were successful in reaching a large percentage of parents, young adults, church members, and other community members in the intervention communities. The Don't Provide campaign had some negative feedback, with a few communities finding the use of young children on the posters inappropriate and refusing to hang them. The "retro" image advertising that was popular at the time was seen by some as too "urban." Because the work for the advertising campaign had been pro bono, we were not able to conduct the usual formative development work. Thus, we strongly encourage those who are planning even modest campaigns to ensure that formative evaluation and pilot work is done prior to implementation.

School Curriculum

Classroom curricula were the core of the Phase I interventions and the interim ninth grade year. These focused on skills development related to parent-child communication, peer and media influences, and community change. The outcomes of Phase I reflect the efficacy of these programs. For Phase II, the amount of available classroom time was limited since there are fewer required classes in the eleventh and twelfth grades, and students' schedules are more flexible with some including employment or college courses.

The Class Action curriculum for eleventh grade students was created by the university staff based on the Minnesota State Bar Association's popular Mock Trial Program, emphasizing social and legal consequences of alcohol use. The curriculum framed underage drinking as a community-wide problem and gave students the opportunity to debate the legal intricacies of alcohol-related cases. The hypothetical civil cases involved personal injury or property damage resulting from provision of alcohol to minors at home, the use of alcohol by a pregnant adolescent, commercial sale to a minor and resulting violence, a community festival where minors were drinking, a coach's lack of enforcement of the state athletic association's rules against alcohol use, and a date rape resulting from alcohol use at a party. The defense was presented via videotapes that were made using law students acting as the defense attorneys. A day-long teacher training session was held prior to program implementation.

Class Action was designed to provide the students with analysis skills using alcohol-related legal problems. The students found presenting their cases in class difficult, even though the cases were of interest and relevance to them, because they are not often called to speak in public about a community issue. The students also would have preferred if teams had debated each other rather than having the defense of each case presented by videotape. We had selected the latter method because we wanted more cases to be discussed in class, but we also wanted the teams to be forced to think of ways in which providing alcohol to minors was illegal and irresponsible, as well as a community-level problem. The curriculum was clearly a new approach to prevention for these students and provided instruction on the broad ramifications of adolescent drinking.

Complementary Components

In both phases of Project Northland, the intervention components were designed to be complementary and developmentally appropriate. In Phase II, supply reduction was given priority as an intervention goal, just as demand reduction had been for Phase I. The community action teams, guided by the normative expectations shown in Table 5.1, had the goal of reducing commercial and social access to alcohol. Parents were sent direct messages concerning the norms, the action teams' activities, and what they could do at home to reinforce nondrinking. The youth action teams' activities were guided by the goals of reducing commercial and social access to alcohol, although they primarily addressed social availability. The mass media publicized action team activities and mobilized the public about issues of access. This was particularly potent when young buyers attempted to purchase beer in local establishments (compliance checks) in collaboration with the local police. Then, "ease" of access to alcohol became localized and relevant. The Don't Provide campaign also focused on preventing access by young adults. Finally, the classroom curriculum, Class Action, dealt with the penalties of providing alcohol to adolescents and encouraged townspeople to think about the problem of teen alcohol use from a community perspective.

Outcomes

The results of Phase II were quite positive, particularly given the attenuation that had occurred between the eighth and tenth grade. The multi-component community-wide approach, targeting high school students' access to alcohol and changing community norms, was effective in reducing the increase in alcohol use in the intervention communities. The trend data showed significantly less increase in alcohol use among students in the intervention communities, as measured by the Tendency to Use Alcohol scale, binge drinking, and marginally, past month alcohol use ($p<.07$). The Tendency to Use Alcohol scale

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incorporates intentions to use alcohol in the future as well as current levels of use, so provides a dynamic measure of alcohol use for this population. The reduction in binge drinking is particularly important, since underage youth have been shown to engage in more binge drinking than those of legal drinking age, and is clearly a problem for this younger age group. We also observed significantly reduced access to alcohol in the intervention communities, as measured by purchase attempts by young-looking 21-year-olds.

Implications for Practice

Project Northland faced several challenges during Phase II that are relevant to practitioners, in addition to the development and implementation issues that have been discussed above. The first is the challenge of working with high school students, among whom alcohol use is normative and "no use" messages less popular than with a younger age group. The emphasis on availability and access shifted the focus from the students to the community, which is appropriate, and also shifted the responsibility from the individual teen (to say "no" to alcohol) to adolescents and adults who might provide alcohol at social events or in commercial settings.

A second challenge of working with high school students is that they have less flexibility in their school schedules than younger students, more demands on their time, and greater independence from teachers and parents, making direct educational interventions more difficult to schedule. Therefore, the concept of the social environment of high school students had to be expanded from parents, peers, and schools to be able to reach adolescents in new environments.

A third challenge was in trying to shift the community's focus from education to action, that is, trying to create changes at the community level when norms are deeply entrenched. Even among the trained and motivated organizers, maintaining this focus on community policies and practices required ongoing communication, training, support, and supervision.

We approached these challenges by expanding the intervention components so that the strategies targeted the broader social environment of older adolescents and provided consistent messages around alcohol use. Thus, high school students were exposed to Project Northland via their schools, peers, families, media, religious institutions, and community members. This multicomponent approach, based on changing community norms, made it more likely that high school students had less access to alcohol and reduced their rate of drinking.

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What types of sex offenses do juveniles commit?

Do juveniles who commit sex offenses differ from those who commit nonsexual offenses?

Are there ways to prevent juveniles from becoming sex offenders?

What resources do parents need when they discover that their child has committed a sexual offense?

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Juveniles Who Have Sexually Offended: An Introduction

By Sue Righthand, Ph.D. and Carlann Welch, Psy.D.

Sexual abuse has been recognized as a significant problem in our society. Adult sex offenders frequently begin their abusive behavior during their adolescence or earlier. Studies have found that approximately half of adult sex offenders began their sexually abusive behavior before adulthood. In addition, sexual abuse by juveniles results in significant numbers of victims. For example, Federal Bureau of Investigation Uniform Crime data indicate that in 2000, 16% of arrests for forcible rape and 19% of arrests for all other sex offenses involved youths under 18 years old. Still, the scope of the problem may be underestimated, because juveniles who commit sexual offenses and become known to the system may represent only a small proportion of those who have committed such offenses.

A review of the professional literature conducted by the authors suggested that programs for these youths frequently have been based on knowledge and interventions designed for adult offenders without adequate consideration of the developmental issues and needs unique to juveniles. There are important distinctions that differentiate juveniles from adult sex offenders.

In fact, the appropriateness and ethics of the term "juvenile sex offender" have been called into question. Language describing these young people as children or teenagers who have sexually offended (rather than as juvenile sex offenders) holds them accountable for their behavior yet does not suggest that they are and always will be notorious sex offenders. Language that emphasizes the behavior rather than the person may help to avoid self-fulfilling prophecies that may contribute to offending behavior by promoting the belief that a person can never be more than his or her past. When the past includes sex offending, this can be a hopeless and esteem-deflating perspective. Because most papers and studies in the literature have used the term "juvenile sex offenders," this term will be used, at times, in this article. Yet, it is important to consider the impact of language and begin to make appropriate changes.

Characteristics of Juveniles Who Have Committed Sex Offenses

Juveniles who have committed sex offenses are a heterogeneous mix. They vary according to victim and offense characteristics. They also differ on a wide range of other variables including types of offending behaviors, histories of child maltreatment, social and interpersonal skills and relationships, sexual knowledge and experiences, academic and cognitive functioning, and mental health issues.

In spite of the apparent heterogeneity among juveniles who have sexually offended, studies that compare juveniles who have committed sex offenses with juveniles who have committed only nonsexual offenses frequently have not found significant differences. This finding suggests that the characteristics of a substantial number of juveniles who have committed sex offenses do not differ significantly from juveniles who commit other types of offenses, although subgroups may differ.

Offending Behaviors and Characteristics

Sexual offending behaviors by juveniles range from noncontact offenses (such as exhibitionism and voyeurism) to penetrative acts. For example, Righthand and colleagues found more than half of the offenses committed by the juveniles in their sample involved oral-genital contact or attempted or actual vaginal or anal penetration.

Approximately half of adult sex offenders began their sexually abusive behavior before adulthood.

Offense characteristics include factors such as the age and sex of the victim, the relationship between the victim and the offender, and the degree of coercion and violence used. Girls are targeted most frequently, however boys represent up to 25% of some victim samples. Victims usually are substantially younger than the youth who offended. Victims are usually relatives or acquaintances; rarely are they strangers. Additionally, babysitting frequently provides the opportunity to offend.

Juveniles who have offended typically are less physically violent than adult sex offenders. However, they may secure the victim's compliance through manipulation, intimidation, threats of violence, physical force, or occasionally extreme violence. Juveniles who victimize peers or adults tend to use more force than those who victimize younger children. Some of the "triggers" that have been described as related to sex offending include anger, boredom, and family problems.

(Continued on Page 3)

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From the Editor's PC

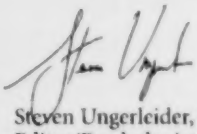
Dear Colleagues:

We are pleased to present this important issue on adolescents who commit sexual offenses. While much has been said about sex offenders and treatment modalities, little has been discussed in the way of prevention. So here we are, hopefully in the forefront of trying to assist our mental health colleagues with prevention-based material. Let us know if we are doing a good job. You can send us comments and feedback via e-mail at feedback@TPRonline.org.

We start this issue with an introductory article on the topic of juveniles who sexually offend by Drs. Sue Righthand and Carlann Welch, clinical and consulting psychologists in Maine. Turning to the topic of prevention, Robert E. Longo, M.R.C., L.P.C., and Geral T. Blanchard, M.A., explore various avenues for prevention, and Alisa Klein, M.A.I.P., and Joan Tabachnick, M.B.A., of STOP IT NOW! discuss the needs of parents of youth who have sexually offended. We further explore the behaviors of youth who sexually offend in an article by Stacey C. Zolondek, M.A., and colleagues at Emory University, and finally, Sheri Bauman, Ph.D., from the University of Arizona, discusses the various ways juvenile sex offenders have been classified. By realizing that not all sex offenders are the same, she feels we can more appropriately intervene.

After you read this issue please pass it along to colleagues who may also find it useful in their work. Adolescents who sexually offend is a topic we often don't discuss, so we hope this issue will generate relevant dialogues among you and your colleagues. As always, we invite you to our web site (www.TPRonline.org) for references and suggested reading lists for all the articles in this issue.

Have a great winter.



Steven Ungerleider, Ph.D.
Editor/Psychologist
The Prevention Researcher

The PREVENTION RESEARCHER

The Prevention Researcher is a quarterly newsletter that acts as an intermediary between researchers and service professionals. Established in 1994, *The Prevention Researcher* publishes professional articles based on the latest research. Each single-theme issue focuses on an at-risk youth topic from a prevention standpoint. *The Prevention Researcher* is indexed in ERIC and CINAHL.

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Recycled Paper

Juveniles Who Have Sexually Offended *(Continued From Page 1)*

Nonsexual criminal and antisocial behaviors frequently are observed in juveniles who have sexually offended. Such behavior may, in fact, be quite typical of these youths, especially those who engage in forcible sexual assaults such as rape and attempted rape. In a national survey, Elliott found that most of the 80 juveniles who disclosed sexually assaultive behavior had previously committed a nonsexual aggravated assault, whereas relatively few (7%) had perpetrated exclusively sex offenses. Studies of adult sex offenders have found nonsexual (violent and nonviolent) criminal behavior is correlated with repeated sexual violence. This also may be an important risk factor for repeated sex offending by juveniles.

Child Maltreatment and Family Functioning

The childhood experience of sexual abuse has been associated with juvenile sex offending. Rates of sexual victimization experiences from 40 – 80% have been reported. However, such sexually abusive experiences have not consistently differentiated these youths from youths who have committed other types of offenses.

Childhood experiences of being physically abused, being neglected, and witnessing family violence have been associated with sexual violence in juveniles.

Childhood experiences of being physically abused, being neglected, and witnessing family violence also have been associated with sexual violence in juveniles. Judith Becker and John Hunter reported that between 25 – 50% of juveniles who had committed sexual offenses had been victims of physical abuse. A study by researchers Ford and Linsey that compared youths who had sexually offended with those who had committed nonsexual offenses suggested that those who committed sexual offenses may have had higher rates of childhood physical abuse. This finding was not replicated in a study by Raymond Knight and Robert Prentky that compared juveniles who had sexually offended with juveniles who committed nonsexual violent offenses. This latter finding suggests that a history of physical abuse is correlated with violent behavior in general, not just sexual violence.

The role of child maltreatment in the etiology of sex offending appears quite complicated. John Hunter and Aurelio Figueredo used several comparison and control groups to investigate factors associated with sex offending, such as history of sexual victimization and family support. The study found four variables predictive of sex offending: younger age at the time of victimization, higher rates of abusive incidents, longer period between abuse and disclosure, and lower level of perceived family support following the disclosure of the abuse.

In addition to child maltreatment, factors such as instability, disorganization, and violence often have been observed in the family histories of juveniles who have committed sexual offenses. Studies vary as to the percentages of these juveniles who are from intact families.

Research also has examined family communication styles and types of family involvement with these youths. Studies have found supportive communication and comments that facilitate dialogue are limited; whereas negative communication, such as aggressive statements and interruptions, are frequent. Furthermore, adequate supervision may be lacking.

Social Skills and Relationships

Research has repeatedly shown that juveniles who have engaged in sexual offending have significant deficits in social competence. Inadequate social skills, poor peer relationships, and social isolation are some of the difficulties identified among these youths. For example, Michael Miner and C.L Crimmins found that juveniles who had sexually offended had fewer peer attachments and felt less positive attachment to their schools, compared with other delinquent and nondelinquent groups.

Sexual Knowledge and Experiences

Research studies suggest that adolescents who have sexually offended generally have had previous consenting sexual experiences. Sometimes their experiences have exceeded the experiences of juveniles who have not committed sex offenses. Furthermore, in a study of 1,600 juvenile sex offenders described by 90 independent contributors from 30 states, Gail Ryan and colleagues found that only about one-third of the juveniles perceived sex as a way to demonstrate love or caring for another person; others perceived sex as a way to feel power and control (23.5%), to dissipate anger (9.4%), or to hurt, degrade, or punish (8.4%).

Academic Performance

Studies typically report that, as a group, juveniles who have sexually offended experienced academic difficulties. For example, Timothy Kahn and Heather Chambers found that more than half of the juveniles in their study evidenced at least one of three kinds of difficulty at school: disruptive behavior (53%), truancy (nearly 30%), or a learning disability (39%). Only 57% of the sample had achieved grade-appropriate placement or better. In contrast, some of these youths do well in school. For example, Michael O'Brien found that 32% of his sample was described as above average in their academic performance.

Cognitive Distortions and Attributions

Some difficulties observed among abused children may have relevance for juveniles who have committed sex offenses and who also have been maltreated. For example, Knight and Prentky noted research findings indicating that abused children evidence less empathy than nonabused children, have trouble recognizing appropriate emotions in others, and have difficulty taking another person's perspective. This observation is consistent with studies indicating that cognitive distortions, such as blaming the victim, are associated with increased rates of juvenile sexual reoffending.

Other Issues

Sibling Incest

Few reports have specifically addressed issues pertaining to sibling incest; however it appears to be quite prevalent and is often under-reported and ignored. O'Brien compared 170 juveniles from four different groups—those who sexually offended against siblings (including stepsiblings, half siblings, and adoptive siblings), extra-familial offenders (who offended against children other than their siblings), those who sexually victimized peers or adults, and those whose victims may have included a mix of sibling and extra-familial children and/or peers and adults. As a group, those who offended against their siblings committed the greatest number of abusive acts, perpetrated sex offenses over the longest time periods, were more likely to vaginally or anally

penetrate their victims, and were more likely to have multiple victims. O'Brien hypothesized that specific issues such as victim availability and the nature of the sibling relationship may have contributed to such serious offending histories. In spite of such abusive behaviors, only about one-third of the sibling offenders had court-ordered treatment, compared with three-quarters of the other offenders.

Girls Who Have Committed Sex Offenses

Research studies on adolescent girls who have committed sex offenses are relatively rare. Existing studies often are limited by small sample sizes and retrospective analysis of selected populations that may not be representative of the general population. The percentage of girls who have sexually offended has been found to range from 2% to 21.6%. Incidence reports on juvenile sex offenses may underestimate the extent of the problem for girls even more than for boys. Underestimates may occur because of a general tendency for victims, family members and others to underreport sex crimes committed by females, perhaps because of a societal reluctance to acknowledge that girls are capable of committing criminal offenses, particularly sex offenses.

Conclusion

Juveniles who have committed sex offenses are a heterogeneous group. Like all juveniles, they are experiencing significant cognitive, emotional, and social changes consistent with their stage of development. They also have special needs as reflected in this article regarding the factors that have been associated with their patterns of sexual and nonsexual offending. Moreover, when considered as a group, they present special risks due to their abusive behaviors.

The literature clearly supports the importance of employing interventions that are tailored to the individual juvenile. It should be remembered that although the goal when working with juveniles who have committed sex offenses is to help them stop their abusive behaviors, they are children and adolescents first. They are young people who have committed offenses and who warrant care and attention.

Sue Righthand, Ph.D., is a Clinical and Consulting Psychologist in Rockland, Maine. Carlann Welch, Psy.D., is a Clinical and Consulting Psychologist in Portland, Maine.

This article has been condensed from S. Righthand and C. Welch (2001). *Juveniles Who Have Sexually Offended: A Review of the Professional Literature.* Office of Juvenile Justice and Delinquency Prevention. It appears here with permission. The full report, with complete references, is available online (ojjdp.ncjrs.org/pubs/general.html).

GLOSSARY

Cruising: The active seeking out of a victim for purposes of engaging in deviant sexual activity.

Exhibitionism: Exposing one's genitalia to others for purposes of sexual arousal.

Fetishism: Use of nonliving objects (e.g., shoes, undergarments, etc.) for sexual arousal that often involves masturbation.

Frotteurism: Touching or rubbing against a non-consenting person for sexual satisfaction, usually happens in crowded places like subways, elevators, or shopping malls.

Grooming: The process of manipulation often utilized by child molesters, intended to reduce a victim's or potential victim's resistance to sexual abuse. Typical grooming activities include gaining the child victim's trust or gradually escalating boundary violations of the child's body in order to desensitize the victim to further abuse.

Incest: Sexual relations between close relatives, such as father and daughter, mother and son, sister and brother. This also includes other relatives, stepchildren, and children of common-law marriages.

Paraphilia: A deviation in normal sexual interests and behaviors that may include exhibitionism, frotteurism, pedophilia, and voyeurism, among many others.

Pedophile: An individual who turns to prepubescent children for sexual gratification.

Sex Offender: The term most commonly used to define an individual who has been charged and convicted of illegal sexual behavior.

Sexual Abuser: The term most commonly used to describe persons who engage in sexual behavior that is considered to be illegal (this term refers to individuals who may have been charged with a sex crime but have not been convicted).

Voyeurism: Observing unsuspecting individuals, usually strangers, who are naked, in the act of dressing or undressing, or engaging in sexual activities.

Modified from Glossary of Terms Used in the Management and Treatment of Sexual Offenders, (1999), by the Center for Sex Offender Management. The full glossary is available on their web site (www.CSOM.org). Used with permission.

Prevention of Sexual Offending Among Adolescents

By Robert E. Longo, M.R.C., L.P.C. and Geral T. Blanchard, M.A.

Using the public health model, there are three levels of sexual abuse prevention—primary, secondary, and tertiary. The goal of primary prevention is to prevent sexual abuse before it occurs. Primary prevention puts responsibility on the would-be abuser to not sexually abuse others. Primary prevention invites those who believe they have a problem to seek help and treatment, promoting a message of hope and recovery.

The goal of secondary prevention is to teach people how to avoid becoming victims. In its most familiar forms, secondary prevention includes child sexual abuse prevention and awareness programs in schools, rape awareness, prevention, and education, and self-defense classes. Although crime prevention programs and efforts are valuable, secondary prevention programs place the responsibility for sexual abuse prevention on the potential victim. Another form of secondary prevention identifies "at risk" individuals who may be susceptible to becoming either abusive or abused, and intervenes to reduce that risk.

The goal of tertiary prevention is to stop the abuse from continuing. This may involve treating victims of sexual abuse and teaching them ways to avoid and/or prevent sexual abuse from happening again. Treating sexual abusers and helping them learn ways to not sexually abuse again is another form of tertiary prevention. While treatment is a valuable and worthwhile effort, the problem with this level of prevention is that it occurs after someone has been abused.

The goal of this article is to highlight current child sexual abuse prevention efforts using the public health model.

Primary Prevention

Sex Education

Many people do not consider sex education as a tool for preventing sexual abuse of children. But sex education is a cornerstone for preventing sexual abuse and especially the sexual abuse of children. Sex education should be taught both at home and as a core subject of school curricula. Children need to learn from an early age that their bodies, especially the sexual parts, are personal and private. Four-year-olds don't need to have information about procreation, but they do need information about how to be safe and to know they can talk to adults about sexual thoughts, feelings, and behaviors.

Many sexual abusers exploit a child's curiosity, need for attention, and lack of knowledge about sexuality. In some cases, sexual abusers use erotic materials and pornography to desensitize, normalize, and entice children to engage in sexual activities. When children's legitimate questions go unanswered by parents and teachers, molesters may offer information as a means of engaging children in sexual activities.

Sex education should provide children with age-appropriate information about anatomy, social customs, sexual feelings and behavior, and reproduction. Children need accurate and honest information to counter the messages and images they are subjected to through television, advertisements, movies, and pornography. That information should never be delivered in a way that associates bodies or sex with shame or fear; those methods have been shown to be ineffective.

In addition, sex education should provide children and adolescents with information that might deter them from engaging in sexually abusive acts. Many abusers have had no formal sex education and their beliefs, attitudes, and knowledge are based upon inaccurate information and distortions. Over 85% of programs treating people who have been sexually abusive teach sex education as a part of the therapeutic process.

STOP IT NOW !

STOP IT NOW! is a national organization established to introduce a new approach to preventing the sexual abuse of children. Its unique mission is to make child sexual abuse a recognized public health issue. Through public education, research, and policy changes, STOP IT NOW! is shifting people's attitudes and behaviors similar to other organization's effects on such public health issues as drunk driving and smoking.

Many sexual abusers exploit a child's curiosity, need for attention, and lack of knowledge about sexuality.

STOP IT NOW! VERMONT was launched in 1992 as a pilot media and outreach campaign of STOP IT NOW! This program targets abusers and potential abusers, adults who may know an abuser, and the parents of sexually abusing youth. (For more information about STOP IT NOW!'s work with parents, see "Finding Ways to Effectively Prevent Sexual Abuse by Youth" on page 8). Through news items, advertisements, public service announcements, brochures, workshops and conferences STOP IT NOW! VERMONT challenges each of these targeted audiences to confront the behaviors and take action. The goals of the campaign are to:

- Challenge abusers to stop their abuse immediately and seek treatment
- Empower family, peers, and friends to confront abusing behaviors
- Educate parents about the differences between healthy sexual development and sexual abuse, and provide information about where to seek help
- Create a social climate that will not tolerate the sexual abuse of children
- Build public knowledge about what to do when the warning signs of an abuser are visible.

One of its innovations is a confidential telephone information and help line for abusers, potential abusers, and people who may know an abuser. The program does not provide amnesty, but gives information on treatment as well as a protocol to follow for abusers turning themselves in to the legal system and receiving treatment. Until now, no program has tried to reach this audience, nor tracked the number of abusers who will come forward. Of the 657 calls to the help line, 15% were from people who self-identified as sexual abusers.

STOP IT NOW! hired an outside evaluation firm to conduct random telephone surveys in 1995, 1997, and 1999. In 1995,

only 45% of the respondents could explain or define the term "child sexual abuse." In 1997 that number rose to 65%, and in 1999 it rose to 85%. Additionally, residents were almost twice as likely to call child protective services in 1999 than in 1997 if they suspected or knew of a case of sexual abuse. However, the survey also found that many people are still not able to accurately define a scenario as sexual abuse, so an education campaign to increase the public's knowledge would be helpful. Today, STOP IT NOW! has projects in Philadelphia, Minnesota, and the United Kingdom, with a long-term evaluation being conducted by the CDC at the Philadelphia site.

Secondary Prevention

Child Sexual Abuse Prevention Programs

Child sexual abuse prevention programs and education efforts have been available for less than two decades. Many of these educational efforts teach children about appropriate and inappropriate touch, being assertive, and saying "no" to people who touch or want to touch them in a sexual manner. Although child sexual abuse prevention education is a valuable aspect of prevention, questions remain pertaining to children's abilities to learn and retain the materials. In addition, researchers remain concerned about whether children with less physical power and knowledge of consequences are capable of resisting sexual abuse attempts by stronger and/or older abusers.

Concern also exists about the potential for negative effects from these efforts. Although many children have benefitted from sexual abuse prevention and education programs, some children report (and their parents confirm) negative effects. In fact, there is some criticism that these programs may cause the children who participate in them increased anxiety or fear about potential abuse, or they may become oversensitive to appropriate situations, or may develop negative attitudes toward sexuality. Another negative effect of teaching children prevention strategies may be that children and parents become overly confident and fail to employ other reasonable protection strategies.

Child sexual abuse education and prevention programs are an important component in child sexual abuse prevention. However, these approaches place 100% of the responsibility for personal safety on children who cannot be expected to defend themselves from stronger, more sophisticated adolescent and adult abusers. Adults must ultimately retain responsibility for keeping children safe. Studies regarding the effectiveness of sexual abuse prevention education programs are currently inconclusive.

Sexual Abuse Victim Treatment

No one is exempt from being the possible victim of sexual abuse. In our clinical practices we have seen both men and women who have sexually abused both male and female children and adults. After someone is sexually abused, it is important for them to be evaluated for needed treatment. Sometimes, short-term counseling is sufficient, and, depending on the age of the child, a few follow-up sessions may be necessary as each developmental milestone is reached. In other cases, long-term counseling or residential treatment is indicated. Without evaluation and treatment, the victim of sexual abuse may experience acute and/or chronic problems that decrease the quality of their lives. This is especially true for child victims of sexual abuse. Children's ability to form trusting relationships with others, develop positive self-esteem, empathy, self-confidence, identify and effectively express emotions, and function well in daily life may be affected significantly. Fortunately, children can be highly resilient and are likely to respond well to early interventions which offer validation, protection, and reassurance. Unfortunately funding for treatment is often the responsibility of the victim and/or the victim's family. Lacking the ability to pay, many victims are placed on waiting lists for reduced-fee, free, or very short-term emergency counseling. Many receive no help at all.

Research suggests that some sexual abuse victims have also engaged in limited and undetected sexually abusive behavior. A small percentage (less than 15%) of adolescent and adult victims have admitted, during treatment, that they have acted out their anger sexually on another individual. Because some victims have the potential to act out sexually, treatment of sexual abuse victims is an integral part of prevention.

Understanding the potential for repeat victimization is also important to prevention because of the high incidence of repeated sexual abuse by abusers on their victims. It has been our experience as clinicians that sexual abusers will tell their victims, "If you tell, I'll go to prison." The victims' feelings of guilt and sense of responsibility for this horrendous outcome decreases their likelihood of reporting. If society approached sexual abuse as a treatable and preventable public health problem, such threats would likely be less effective in silencing the victims and the abusers would likely be more open to the idea of seeking treatment. Our work with the families of intrafamilial sexual abuse tells us that in many cases sexual abuse would have been reported much sooner if such threats to the families did not exist.

Understanding the potential for repeat victimization is also important to prevention.

Tertiary Prevention

Sexual Offender Treatment Programs

People often ask us if there is a "cure" for sexual abusers. People define cure differently and we do not want to debate the definition of cure. However, when people ask about cures for sexual abusers, they generally mean a treatment that renders the person safe and no longer at risk to engage in sexually abusive behavior. What we can say today is that hundreds of thousands of individuals have participated in specialized treatment programs and have gone on to lead productive lives and have not been rearrested. The quality of their lives has improved and it appears they are avoiding further sexually abusive behaviors; a testament to the success of some treatment programs.

The Pre-Sentence Alternative Program

Through a local collaboration between a law enforcement officer, a treatment provider, a state's attorney, a social service director, and a diversion director, the Pre-Sentence Alternative Program (PSAP) was created in a Vermont community. This program allows citizens to participate in preventing future incidents of child sexual abuse.

Although PSAP evolved from the diversion model, a voluntary program for first-time offenders, its components are much more extensive. The incentive behind the program is that it offers the abuser the freedom to admit responsibility and get the treatment needed without earning a conviction record. Through treatment, PSAP offers restitution to victims, gives abusers the tools needed to understand and manage their abusive behavior, and keeps the community safe.

Abusers meet with a review board of community volunteers trained in understanding the complexity of sexual abuse. The review board works with abusers to change destructive behaviors and offer support for positive changes. The abuser knows he or she will be held accountable for past and present behavior. This accountability includes a consistent and truthful approach requiring a strict adherence to the rules of the program.

All juveniles referred to PSAP must admit responsibility for the offense and a parent or guardian of the abuser must agree to be involved in the treatment process. This involvement usually entails attendance at a monthly support group with the purpose of opening the channels of communication and offering education about sexual abuse issues. The PSAP program also encourages victims to give input regarding the impact of the offense on them. It requires the offender to reimburse the victim for any treatment or other service they have had to pay for. If the victim has not received treatment, or prefers not to participate, the offender is often required to make a contribution to the county victim assistance fund.

The PSAP is able to use community resources to hold a juvenile offender accountable:

- For breaking the silence surrounding sexually offending behaviors by involving the community,
- For restoring the victim and preventing future victims,
- To the family, therapy group, and treatment provider who offer support for the offender, and
- To the legal system which helps avoid denial and minimizing on the part of the abuser, while offering a cost-effective, meaningful alternative to the traditional criminal justice system.

Since its inception 15 years ago, approximately 87 offenders have been referred, about 40 have successfully completed treatment, 22 are still in the program, and the remaining offenders were either rejected at referral or did not complete the program. The average PSAP case duration is 3.5 years and abusers pay their own treatment costs. The PSAP legally mandates treatment, holds the abuser accountable, and gives the abuser the opportunity to avoid criminal conviction. This program is in need of a formal evaluation before it is replicated elsewhere, however, to the knowledge of the people working at PSAP, the program has not had one reoffense from the clients that have successfully completed the treatment program.

Transformative Justice

Canadians, along with Australians and New Zealanders, make reference to restorative justice, transformation justice, and satisfying justice. All are quite similar and argue in support of greater victim and community involvement. Just as important is a diminished emphasis on adversarial court proceedings that increase tensions and do little to heal victims or abusers. Reconciliation and restitution are important components of most programs based on these ideas of justice. Mediation is encouraged. Punishment is seen as a measure of despair that has little to do with justice and even less to do with healing the injured parties. Whenever reasonably possible, it is the desire of community justice teams to keep offenders in the community where "reintegrative" shame can be experienced. Abusers are expected to face the pain and humiliation brought on by their crimes and not have incarceration serve as an escape.

Citizens are empowered when the courts allow them the initiative for alternative sentencing. This becomes a labor-intensive process in which citizens must meet victims and abusers and participate in sentencing, treatment, and probationary responsibilities.

On a more intimate level, some communities participate in family group conferencing. This approach to crime tends to bring smaller numbers of people together than do community-based programs. Usually the victim, the perpetrator, and their families come together to mediate solutions outside the courtroom. The goal is to connect or reconnect the abusers to family and community. Abusers may thereby feel more guilt, but at the same time, are less alienated. Always the ultimate goal is the restoration of social bonds and the reintegration of each affected person back into the community.

These are truly revolutionary approaches to justice. Yet, most have their origins in ancient aboriginal traditions that are being revisited and reworked to address the crimes of today. The solutions for the future have been right behind us where we are least inclined to look. It is time for us to investigate the solutions that other nations and cultures have developed. They offer us great hope.

Restorative Justice

The restorative justice model seeks to redefine crime and punishment and counters the retributive model we have been following for many years. It considers crime as an injury to the victim and the community not primarily to the state. Restorative justice considers imprisonment as punishment with no restorative value to the victim of crime or the criminal.

To reduce sexual abuse in America, citizens must work on preventing it from occurring.

Restorative justice seeks to heal victims and abusers while holding the abuser responsible for his or her actions and accountable to others. Communities become involved and the abuser is confronted with the fact that his or her behavior impacts the victim(s) and the community. Therefore, the abuser is encouraged to make restitution to the victim(s) and the greater community. Examples of restorative justice efforts include:

- *Victim-offender mediation sessions:* This process is less likely with stranger-to-stranger sexual abusers and is more common in cases that involve sexual abuse between family members, friends, and acquaintances.
- *Victim restitution:* This is a common approach used with sexual abusers, the abuser may be held responsible for paying the costs of his or her own treatment and that of the victim(s). Lacking these financial resources, the abuser may be required to participate in other activities such as community service and treatment efforts that somehow benefit the recovery of the victim (for example, letters of apology in which the abuser acknowledges responsibility for his or her behavior and absolves the victim of responsibility or blame).
- *Reconciliation and settlement:* This method is not as likely to be used with many sexual abusers, although in those cases involving sexual abuse of family members or victims known to the abuser, it may be more feasible.
- *Victim input on conditions of probation and parole for the abuser:* In this instance, the victims may strongly request or require that the abuser is mandated to participate in treatment.
- *Community services that involve educating others about the wrongs of one's actions such as victim impact panels.*

Assessment and treatment of sexual abusers is a component of a restorative justice model. Once a sexual abuser has pled guilty or has been found guilty of committing a sexual offense, and before sentencing, a comprehensive specialized psychosexual assessment should be performed by an experienced clinician

who specializes in sexual abuser assessment and treatment. Sentencing of the convicted sexual abuser should take place after the evaluation so that risk, dangerousness, and amenability to treatment can be considered.

Summary

We have briefly reviewed both the current strategies for preventing sexual abuse and the promising new approaches. These are but a few examples of how society can move in a more responsible direction regarding sexual abuse prevention. To reduce sexual abuse in America, citizens must work on preventing it from occurring. Prevention requires public education. We believe this is best accomplished by addressing it as a public health issue. Using a public health model holds tremendous promise today for reducing sexual abuse in America tomorrow. Prevention is not punishing a behavior after it occurs. Prevention is stopping the problem before it occurs. -ar-

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This article is condensed and updated from R.E. Freeman-Longo and G.T. Blanchard, (1998). Current Strategies for Sexual Abuse Prevention (Chapter 10) and Prevention for the 21st Century (Chapter 11) of *Sexual Abuse in America: Epidemic of the 21st Century.* Safer Society Press: Brandon VT. It appears here with permission.

Finding Ways to Effectively Prevent Sexual Abuse by Youth

By Alisa Klein, M.A.I.P. and Joan Tabachnick, M.B.A.

Youth with sexual behavior problems pose a complicated challenge to our society. Yet, we as a society have succeeded in developing only a limited range of actions and attitudes to grapple with and prevent this problem. Very few of our social service and criminal justice systems have rallied to create compassionate models that not only address and respond to the complicated issues posed by youth with sexual behavior problems, but that work, with an eye towards prevention. Furthermore, most social services, as well as the criminal justice system, are designed as tertiary prevention approaches—they take action only after sexual violence has been committed. STOP IT NOW!, a national non-profit organization working to prevent and ultimately eradicate child sexual abuse, advocates for adding a public health approach to achieving the primary and secondary prevention of sexual abuse by juveniles—prevention before sexual abuse is perpetrated.

As part of STOP IT NOW!'s public health approach, we have developed both public education and public policy advocacy approaches to ending the almost 50 percent of all cases of child sexual abuse that is perpetrated by children under the age of 18. A central premise of the work of STOP IT NOW! is that children should not be held responsible for stopping their own abuse—our public education programs are geared towards adults and holds them responsible for improving their knowledge, changing their attitudes and taking action to end the sexual abuse of children. One of the three specific adult audiences STOP IT NOW! targets with prevention messages is the parents of youth with sexual behavior problems.

STOP IT NOW! employs a unique, public health-based approach to working with this population. Rather than develop materials that we as professionals want parents to have or understand, STOP IT NOW! has talked with parents directly to hear what they need. We then use this information to develop the prevention messages, support materials, and public policies that will be most helpful to these families.

Formative Research

Over the last 10 years, STOP IT NOW! has interviewed, run focus groups, sponsored public forums, and held a number of evening discussion groups in the State of Vermont with parents of children with sexual behavior problems. Although not conducted as a formal research study, close to 100 parents participated in this STOP IT NOW! research over a 10-year period. Throughout all of the venues, parents offered a list of consistent themes regarding their experiences confronting this difficult issue.

Shame and Isolation

Shame and isolation were often named as a huge issue for everyone in the family: abuser, victim, and each of their family members.

Most social services, as well as the criminal justice system take action only after sexual violence has been committed.

The parents approached by STOP IT NOW! talked about shame for not seeing what was going on, for not doing anything earlier, for not seeing their child's victimization, for not finding the right professional that could help their family, and for not effectively confronting the situation before any further harm was done. One mother told STOP IT NOW! that when she found out her 13-year-old son had sexually abused a neighbor's child, "It felt like my entire world had shattered around me like so many pieces of glass. How could I have missed that my son had sexually abused another child? As a mother, how could I have missed my son's own victimization?"

Parents also described the isolation they felt upon hearing the news that their child may have sexually abused a younger child. Another mother said "It would be easier to tell a friend that my 12 year old son was an alcoholic, a drug addict, or a murderer than to say he is a sex offender." Her husband went on to tell STOP IT NOW! of the isolation their entire family experiences

every day in their small town in rural New England. In most cities and towns across the United States there are no support groups for these parents. In the fall of 1999, STOP IT NOW! held a facilitated evening just for parents of youth with sexual behavior problems in connection with the New England Conference on Child Sexual Abuse. A parent attending the evening commented, "This is the first time in my 10 years of dealing with this difficult issue that I feel normal telling a group that my teenage son sexually abused my daughter."

Inadequate Information

Nearly all of the parents talked about how they did not have easily accessible and specific information to respond to important questions such as:

- What exactly is considered child sexual abuse in their state?
- What is the difference between healthy sexual development and inappropriate sexual activities?
- What are the signs that a child may have been sexually abused or at-risk for perpetrating sexual abuse?
- What are the specific steps they should take if they suspect inappropriate sexual activity that may be sexually abusive?
- What will happen to each person in their family if they choose to make a report or talk with a mandated reporter?

One parent described how his family had been concerned about their eight-year-old son's inability to concentrate at school. As concerned parents, they took him to their local doctor, a well-known therapist, and to a children's hospital in a major city. The family never suspected that the lack of concentration, the nightmares, and bedwetting may have been from the sexual abuse their son was experiencing. Not one of these professionals asked about the potential of sexual abuse. When the son reached his teens, he sexually abused his younger cousins.

Message of Hope

Parents wanted to hear first and foremost that their child could still grow up to live a productive and sexually healthy life despite his or her current or past sexual behavior problems. Many also voiced an interest in hearing more from others who shared their experiences of sexual abuse in their family. They longed to hear about other families that had confronted the sexual abuse in their lives, and especially from those whose families learned to live healthier lives as a result of their willingness to deal openly with sexual abuse. Families repeatedly asked for stories about how others have lived through the ordeal of recognizing sexually abusive behaviors in one's child. One such story described the day a 13-year-old boy told his parents that he had sexually abused an eight-year-old neighbor. One of his parents told STOP IT NOW!, "Even though that was one of the worst days of my life, I feel lucky. We work together and let him know he is not alone in this. We are watchful with him and we can talk together about whether a situation is 'safe' for him or not. I feel lucky that we've come through this and that my son took responsibility for changing his behaviors."

Materials Developed

As a result of this formative research, STOP IT NOW! sought funding sources to develop a set of materials that would address the parents' concerns that had been voiced so clearly. However, with only a limited number of potential sources available, STOP IT NOW! also found private partners willing to contribute time and resources for these materials. Given the lack of positive images and scenarios conveyed in the press about what a parent can do to prevent the perpetration of sexual abuse by his or her child, STOP IT NOW! decided to develop and disseminate more proactive scenarios that parents could use as models and as sources of hope. Some of the materials included:

- A series of public service announcements created in collaboration with a local Vermont television affiliate of the WBTV.
- STOP IT NOW! created "town meetings" in Vermont where parents could talk publicly with other parents and professionals about their experiences of uncovering and healing sexual abuse. The press' reporting of the public dialogue on television stations and radio programs, and in the local newspapers, extended this outreach effort to many more at-risk families.
- The PARENTalk Newsletter. Because information designed specifically for parents of sexually abusing youth was difficult to find, STOP IT NOW! created and produced a free quarterly newsletter for parents that contained the stories of parents who are also coping with children with sexual behavior problems. The Newsletter also includes an "expert column" by a well-recognized treatment provider discussing what he has learned working with youth with sexual behavior problems.

Proposed Policy Changes

Given the depth of experience shared by these parents, STOP IT NOW! called upon them to share their thoughts about potential public policy changes for the creation of a social environment that can deal effectively with the issue of youth with sexual behavior problems. Although much of the policy and procedures developed in this field affect their daily lives, they are rarely solicited to provide feedback to key agencies and stakeholders. These are just some of their suggestions:

Parents often felt pulled between social service agencies and the court system.

- *For the legal and social services systems:* Parents said they often felt pulled between social service agencies and the court system. They suggested that partnerships between judicial and mental health systems be formed so that families are not stretched between these two systems.
- *For those who investigate cases of child sexual abuse:* Develop a checklist for parents about what they should do when they are told that their child is accused of sexually abusing another child. Parents suggested that the checklist include: information about local treatment providers trained to work with families dealing with this issue; resources, crisis numbers, and books to help educate everyone within the child's community; practical information about how to talk with the child or adolescent accused of sexually abusing and other involved family members; and tips on how to stay "safe" during this period of disclosure and high stress. Parents also suggested that this information is given as early as possible, even before the investigation is over.
- *For clinicians who work with children:* Parents repeatedly asked that clinicians develop a new model to treat children and not simply transfer what has been learned from working with adult sex offenders.
- *For all systems:* Educate, educate, educate. Professionals need specialized training and people working with the system (e.g., foster parents) need a broader orientation including information on healthy sexual development as well as inappropriate and abusive sexual behaviors.

These recommendations for policy change emphasize the need for systems collaboration, specialized treatment for children, and education for adults. However, in many locations

throughout the United States, there is little or no treatment available for youth with sexual behavior problems. There is little to encourage parents who want to take responsibility for the abusing behaviors of their children to change the circumstances that led to the sexual abuse. This formative research conducted by STOP IT NOW! suggests that the current combination of policies such as community notification and "one-strike and you're out" for juvenile offenders does little to encourage families to take responsibility to step forward and get help from the system when it is clearly needed. Alternately, and in keeping with the suggestions of the family members interviewed, STOP IT NOW! suggests the need for a public health approach to policy development that identifies three opportunities for intervention and prevention:

At the tertiary prevention level (after sexual abuse has been committed): develop policies that call for the provision of specialized treatment and support for both youth who have sexually abused, and for their families. Promote research for the development of standards of practice for treating youth with sexual behavior problems.

At the secondary prevention level (which addresses those at risk for sexually abusing): create policies that call for research to identify the risk and protective factors for the development of sexual behavior and abuse problems. Develop programming that will identify and reach out to youth with sexual behavior problems, and who appear at risk for perpetrating sexually abusive acts, and their families. Intervene by providing specialized treatment and support for the youth and their families before any abuse is committed.

At the primary prevention level (geared towards the general population to prevent the onset of sexual behavior problems and abusive behavior): create policies to educate the general public, particularly anyone who works with or cares for children, about the development of risk and protective factors for sexual behavior and abuse problems. Offer tools and venues for action to prevent sexual abuse before it is perpetrated. Further, develop and implement curricula for mass scale education of adults and children on healthy sexuality and sexual development.

Through a combination of education, support, and policy change, we can work to reduce and prevent the development of sexual behavior problems and abusive behaviors in children and adolescents. Using a public health approach that elicits information from the families who have been most directly affected by sexual abuse, we have developed programs and policies that not only punish, but offer the kinds of knowledge, support and empowerment for behavior change that promote the prevention of sexual abuse by youth.

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For more information about STOP IT NOW! please visit their web site (www.STOPITNOW.com).

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Myths and Facts About Sex Offenders

Myth: Most sexual assaults are committed by strangers.
Fact: Most sexual assaults are committed by someone known to the victim or the victim's family, regardless of whether the victim is a child or an adult.

Myth: The majority of sexual offenders are caught, convicted, and in prison.
Fact: Only a fraction of those who commit sexual assault are apprehended and convicted for their crimes. Most convicted sex offenders eventually are released to the community under probation or parole supervision.

Myth: Most sex offenders reoffend.
Fact: Reconviction data suggest that this is not the case. Further, reoffense rates vary among different types of sex offenders and are related to specific characteristics of the offender and the offense.

Myth: Sexual offense rates are higher than ever and continue to climb.
Fact: Despite the increase in publicity about sexual crimes, the actual rate of reported sexual assault has decreased slightly in recent years.

Myth: Sex offenders commit sexual crimes because they are under the influence of alcohol.
Fact: It is unlikely that an individual who otherwise would not commit a sexual assault would do so as a direct result of excessive drinking.

Myth: Children who are sexually assaulted will sexually assault others when they grow up.
Fact: Most sex offenders were not sexually assaulted as children and most children who are sexually assaulted do not sexually assault others.

Myth: Juvenile sex offenders typically are victims of child sexual abuse and grow up to be adult sex offenders.
Fact: Multiple factors, not just sexual victimization as a child are associated with the development of sexually offending behavior in youth.

Myth: Treatment for sex offenders is ineffective.
Fact: Treatment programs can contribute to community safety because those who attend and cooperate with program conditions are less likely to reoffend than those who reject intervention.

Myth: The cost of treating and managing sex offenders in the community is too high—they belong behind bars.
Fact: One year of intensive supervision and treatment in the community can range in cost between $5,000 and $15,000 per offender, depending on treatment modality. The average cost for incarcerating an offender is significantly higher, approximately $22,000 per year, excluding treatment costs.

From *Myths and Facts About Sexual Offenders* (2000), by the Center for Sex Offender Management. The full publication, including justification and data for each "fact" is available on their web site (www.CSOM.org). Used with permission.

Types of Juvenile Sex Offenders

By Sheri Bauman, Ph.D.

Although juvenile sex offenders (JSOs) account for a significant percentage of sex crimes committed in this country, researchers have only recently begun to study this population. One line of inquiry has been to investigate sub-types of offenders, in order to determine whether different types of offenders have different personality profiles and risk patterns. Although much of the research on JSOs to date has been inconclusive, those studies that sampled subgroups were more likely to detect significant patterns. A better understanding of such types could lead to improved prevention efforts and to innovations in treatment more tailored to the needs of specific types of offenders.

Typologies Based on Characteristics of the Offense

Several typologies categorize JSOs by the nature of the offense. One such approach considers child molesters and rapists to be different types. Data revealed that child molesters have higher rates of deviant, pedophiliac arousal patterns, while rapists have more conduct problems and are more likely to be aggressive and/or sociopathic. John Bradford and his colleagues grouped offenders into aggressive offenses (sexual assault and rape), hands-off offenses (such as voyeurism, exhibitionism, obscene phone calls), and pedophiliac offenses (offenses against young children). They found a high rate of delinquency and violent behavior in the first group, along with a higher incidence of borderline intelligence (defined as an IQ between 70 and 79). The hands-off offenders were better adjusted in general, and their offenses were described as impulsive and not experienced as sexual. The pedophiliac group was characterized by a high incidence of family violence, poor bonding with parents, and high rates of delinquency.

John Hunter found the most useful distinction to be based on the age of the victims of the offenses: peers or adults, and children. JSOs who offend against peers and adults tend to target females and strangers or casual acquaintances, while those who offend against children have more male victims and more related victims. Those who offend against peers or adults are more often involved in other criminal activity, display higher levels of violence and aggression in the course of their offenses, and consequently use weapons and cause injuries more often. Those who offend against children tend to commit offenses based on opportunity rather than planning, and have low self-esteem and depression coupled with deficits in social skills. They also tend to misuse power or authority (such as babysitting).

A somewhat different approach to typing by offense is that of Darlene Hall and Fred Mathews. Based on a survey of practitioners who treat sexual behavior problems in children and youth, they proposed four groups. One group exhibited developmentally expected sexual behavior. Another group exhibited "sexualized behavior," described as "developmentally problematic self-focused sexualized behaviors" that do not involve any interpersonal contact or touch. The third group, termed "sexually intrusive," was comprised of those whose problematic sexual behavior with others did not use force, coercion or planning, while the final group exhibited problematic sexual behavior with others that employed planning, coercion, or force, called "sexually offending" behavior. Practitioners theorized that two factors were prevalent in the youth in the intrusive/offending groups: a history of victimization, and a problematic "sexual environment" within the child's home. Such environments involved exposure to sexually explicit material, open sexual displays between family members, early sexualization of the child, and sexualization of non-sexual behaviors.

Typologies Based on Characteristics of the Offender

Typologies that group offenders by characteristics of the offender reflect differences in development and functioning, rather than differences in sexual conduct. James Worling derived a four-group typology based on personality test scores of 97 adolescent sexual offenders, and found a relationship between type and recidivism rates. The four groups included:

- Antisocial/Impulsive – characterized as antisocial, impulsive, anxious, unhappy, and rebellious
- Unusual/Isolated – characterized as unusual, undependable, isolated, confused, trusting, and spontaneous
- Over-controlled/Reserved – characterized as emotionally over-controlled, responsible, reserved, reliable, suspicious of others, and rigid
- Confident/Aggressive – characterized as confident, self-centered, outgoing, aggressive, sociable, dependable, organized, and optimistic.

Although the four groups did not differ in age, socioeconomic status, or history of sexual victimization, offenders in the Antisocial/Impulsive group reported significantly more physical abuse by parents than the other groups. These adolescents were also most likely to have had criminal charges for their offenses. While the groups did not differ with respect to recidivism rates for sexual assaults, the Antisocial/Impulsive and Unusual/Isolated adolescents were more likely to be charged with a subsequent criminal offense within a six-year period. No relationship was found between victim age or gender and subgroup membership.

JSOs who offend against children tend to commit offenses based on opportunity rather than planning.

William Pithers and his colleagues attempted to empirically define a classification of children with sexual behavior problems using a cluster analytic procedure. Problematic sexual behaviors were defined as repetitive, unresponsive to adult intervention, equivalent to adult criminal violations, and occurring across time and situations. Their sample was unique in that 35% of the 127 six- to twelve-year old participants were female. These researchers detected five groups:

- Sexually Aggressive offenders, who were disproportionately male, had the highest mean age, and had engaged in penetrative acts more than any other group (penetration was rare in all other groups). This group had the highest percentage of conduct disorder diagnoses, and the least acknowledgment of their own maltreatment.
- The Highly Traumatized group had proportional representation of gender. This group had the highest rate of psychiatric

diagnoses, and reported the highest incidence of their own sexual maltreatment, which began at a relatively young age.

- The Abuse Reactive group, in which males were over-represented, had a high number of psychiatric diagnoses, and a history of childhood abuse. This group had the shortest time interval between their own abuse and the onset of problematic sexual behavior. They sometimes penetrated their victims, occasionally used aggression, and had the highest number of abusive acts against others.
- The Rule Breakers included proportionally more females, had the second highest mean age, and had the greatest number of sexual abusers in their extended families. Sexual abuse was more frequent in their histories than was physical abuse. This group had the longest time between their own abuse and their sexual behavior problems.
- The final group was termed Non-Symptomatic by the researchers because they had the lowest rate of psychiatric diagnoses and the fewest number of victims. Their offenses rarely involved force and while they acknowledged a history of sexual abuse, a history of physical abuse was unusual in this group. This group included proportionally more females than were in the sample as a whole. This suggests that female offenders are more likely to fit this pattern.

An interesting finding was a difference between Sexually Aggressive and Abuse Reactive youth who committed penetrative acts, with the families of the Sexually Aggressive offenders having fewer sexual boundaries than the Abuse Reactive offenders.

Perhaps the most comprehensive typology of JSOs is that developed by Michael O'Brien and Walter Bera based on extensive clinical experience with this population. Known as the PHASE Typology, it defines seven categories of offenders:

- The Naive Experimenter/Abusers are those younger offenders (age 11-13) whose offense(s) are considered "opportunistic sexual exploration," that involved no use of force or threats and typically victimized a young child (age 2-6). The motivation of these offenders is to explore and experiment with sexual feelings.
- The Under-Socialized Child Exploiter experiences social isolation and has prominent feelings of inadequacy and insecurity. These offenders exhibit a more chronic pattern of sexual offenses, and typically use manipulation or trickery to engage a young and available child. The motivation for this group is to find intimacy, self-esteem, and self-identity.
- The Pseudo-Socialized Child Exploiter is generally an older adolescent with apparently adequate social skills and normal personality profile, who is frequently a victim of child abuse or neglect. His or her offenses represent a more chronic pattern, with little guilt or remorse expressed. This type of offender tends to portray the offenses as mutual, intimate events. The motivation for this type is to satisfy the offender's own sexual need without regard for the victim.
- Sexually Aggressive offenders are often charming and social, and have good social skills. They frequently come from chaotic and abusive families. They tend to use force or threats, and the motivation for the offense is to experience power or express anger.
- Sexual Compulsives often come from rigid, closed families with repressed parents. The offenses usually are "hands-off" behaviors that are compulsive in nature. The motivation for the offense is to relieve anxiety or tension, and/or to experience the excitement or thrill.
- Disturbed Impulsive offenders may have a multitude of other problems, such as psychological disorders, substance abuse, and learning problems. Their offenses are typically impulsive, with normal controls impaired by either substances or thought disorders. The motivations for the behavior in this group are complex and not easily categorized.
- The final group is the Group Influenced Offender, who is particularly dependent on peers and whose offense occurs with a peer or a group of peers present. These offenders tend to place responsibility for the incident on either the victim or the others in the group. They are motivated by peer pressure or expectations, and/or an attempt to attain status with peers.

Different therapy issues should be part of a treatment plan for each of these groups, and different treatment settings and levels of supervision may be needed as well.

Implications for Communities and Schools

Efforts to reduce the incidence of juvenile sexual offenses can range from one extreme to the other. In some situations, the behavior is ignored or dismissed as experimentation, without regard to the seriousness of the offense. In other cases, concerns for protection of potential victims lead to incarceration without treatment and without regard for the dynamics of the individual offender.

Most victims of childhood sexual abuse do not become offenders.

Although most victims of childhood sexual abuse do not become offenders, there is strong evidence that this is a causal factor in many cases. Therefore, it is imperative that communities and schools encourage and educate their constituencies (including students, staff, parents, and police) about the importance of prompt and specialized treatment of victims of abuse. Children need to be informed about the importance of not keeping this kind of incident a secret, and assured of the ability of adults to protect them. School personnel need to be observant of children's behavior, and be willing to confront inappropriate sexual behavior as they would any other unacceptable behavior. School sex abuse prevention programs need to encourage children to report incidents of sexual abuse, and to stress that abusers may not be strangers and may even be other children.

The school prevention programs (aimed at potential victims) offered to date have not demonstrated a reduction in sexual abuse, and experts warn that typical programs may in fact have unanticipated negative consequences. These negative consequences include concerns about whether children actually comprehend the messages that are delivered, and concern that the focus on negative messages about sex obscures the normal, healthy, positive aspects of sexual activity. Further, such programs do not typically emphasize issues of gender equality and the sexual socialization of children in society. These issues are the context in which sexual abuse and sex offending by juveniles occurs, and must be addressed if progress is to be made.

Many treatment programs for youthful sex offenders are packaged and delivered in a one-size-fits-all fashion, with uniform treatment plans and settings for all offenders. Many programs assume that all offenders have been victims, while the

research shows this is the case less than half of the time. A focus on remembering and processing presumed past abuse might deflect attention from issues in greater need of attention. This review of typologies strongly suggests that different offenders have different causes, motivations, personalities, needs, and skills. Programs that do not address the unique profile of each client are unlikely to achieve the degree of positive outcomes that individually tailored treatment can attain.

Auxiliary components of treatment, such as anger management and social skills training need to be incorporated as needed. Experts promote the inclusion of sex education in programs for youthful sex offenders. They argue that a critical goal of sex offender treatment should be the development of healthy sexuality, particularly because of research which indicates that many families of sex offenders do not provide adequate sex education. Despite fears that sex education stimulates children to participate in sexual activity, Betty Gordon and Carolyn Schroeder cite research demonstrating that youth who were provided with sexual information actually postponed sexual activity. Answering children's questions about sex in a straightforward manner with developmentally appropriate information can reduce the need to experiment sexually. Children need to understand that "healthy sexuality" occurs in the context of relationship. Adolescents also need to understand that sexual interest is normal, and that they can act on their interest in a variety of ways (including abstention, masturbation, fantasies about age appropriate partners in the context of a meaningful affectionate relationship). If youth learn how to meet their sexual needs in healthy ways, they will be less likely to reoffend. Research testing such hypotheses would be very useful.

Garry Perry and Phyllis Olm described a model sex education program for adolescent sex offenders. The goal is to portray healthy sexual behavior as more enjoyable, and to emphasize that while sexuality is a normal part of human experience, it must be expressed in ways that do not harm oneself or others. The curriculum teaches the distinction between "coercion, compliance, cooperation, and consent." Healthy relationships are presented as having equality, affection, loyalty, and agreement, and it is stressed that children do not have the knowledge to give consent to sex. Human anatomy is explained, and discussion of pertinent issues such as puberty and sexual orientation are incorporated into the program. Youth are assisted in developing empathy, and understanding that their offenses hurt victims. An important component of this program is parent education, in which parents learn how to support the adolescent's healthy sexual behavior and receive information about maintaining an appropriate sexual environment in the home.

When offenders are in the juvenile justice system, cooperation between probation and treatment providers is essential. The juvenile justice system can support the provision of treatment in lieu of incarceration with many offenders, increasing the odds that this behavior is not continued. There is research evidence that treatment reduces recidivism in adult sex offenders, and it is likely that this would apply to JSOs as well, but further research is needed to demonstrate the efficacy of treatment versus incarceration. The justice system may choose to impose alternative sentences, including deferred adjudication based on successful completion of treatment.

Although most juvenile sex offenders do not become adult offenders, appropriate intervention can reduce the number of repeat offenders. Community treatment programs for JSOs should include sex education components for offenders and their families, and schools can provide sex education programs for all children and parents. The National Guidelines Task Force developed guidelines for educators in 1991 that schools should consult in developing and improving their programs. Prompt and appropriate action in cases of child sexual abuse, and increased availability of specialized treatment providers, can help reduce the incidence of future offenses. Continued support of research that will validate these typologies and determine the most effective approaches to treatment of each type will also help to reduce the number of juvenile sex offenders and offenses.

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STOP IT NOW! is a national, public health based, non-profit organization working to prevent child sexual abuse through education of adults, and policy change at the local and national level. Their Web site includes commonly asked questions and answers; warning signs that a child may have been abused; a large list of potential resources for offenders, victims, friends and family; and stories of hope.

Focus Adolescent Services:
Adolescent Sex Offenders
www.focusas.com/AdolescentSexOffenders.html

Focus Adolescent Services provides a wonderful list of links to other web resources dealing with the issue of adolescents who sexually offend. They have ferreted out articles from respected publications such as "Adolescent Sexual Offenders: Issues for Pediatricians" from *International Pediatrics*, and "Adolescent Male Sex Offenders Challenge Therapists' Skill" from *The Brown University Child and Adolescent Behavior Letter*, as well as documents from organizations, the federal government, news reports, and other sources.

National Clearinghouse on Family Violence: Child Sex Abuse
www.hc-sc.gc.ca/hppb/familyviolence

The Canadian National Clearinghouse on Family Violence has a number of online reports dealing with child sexual abuse. They run the gamut with information about juvenile and adult sex offenders, and information for parents, teens, and adult survivors.

Self-Reported Behaviors of Juvenile Sexual Offenders

By Stacey C. Zolondek, M.A., Gene G. Abel, M.D., William F. Northey, Jr., Ph.D., and Alan D. Jordan, B.S.

In the past several years, the subject of sexual abuse has received a great deal of attention from the media. Recently, many stereotypes of the sexual abuser have been perpetuated: the loner, hanging out by the schoolyard or the arcade, or the clergyman, or the man who sneaks into homes at night and kidnaps young girls. While all of these images are different, what they all have in common is that the perpetrator is an adult male. Traditionally, both scholars and the public have viewed sexually abusive behavior as the domain of adult males. However, in recent years, crime statistics have shown that this is not the case, and increased attention has been focused on juveniles who are committing sexually abusive behavior. In fact, studies show that between 15 and 20% of all sexual offenses and up to 50% of all child molestations may be committed by those under 18. Further, studies of adult sexual offenders reveal that many began their offending as juveniles. When adult males are finally brought to the attention of the courts and/or a treatment facility, many have a long history of sexual offending, with many different behaviors, acts, and victims. Clearly, it is important to identify and reach young offenders as soon as possible to insure that they do not continue offending into adulthood.

Background Information

To date, the conclusion that can be drawn from research on juvenile sexual offending is that juvenile sexual offenders (JSOs), like adult offenders, are a heterogenous group. Different studies have reached different conclusions regarding victim characteristics, variety of sexual behaviors, degree of force used, sexual arousal patterns, and motivation for offending. Unfortunately, most information on JSOs comes from either clinical writings or from retrospective studies of adults. Studies using samples of JSOs tend to have small sample sizes and, to date, no studies have used standardized instrumentation to collect information. Finally, studies often characterized JSOs as performing hands-on vs. hands-off offenses but rarely differentiate sexual behaviors into the specific categories of sexual offenses found in adult samples.

Description of Study

The overall goal of this study was to collect information on a large sample of JSOs throughout the United States using a standardized instrument in order to begin painting a clearer descriptive picture of this population. Specifically, there were five goals of this study. The first was to gain an understanding of the deviant sexual behaviors of the JSOs referred for treatment. We wanted to know what behaviors they were engaging in, at what age they began, and how many victims they had offended against. Second, we wanted to compare this information with the behaviors reported by a sample of adult offenders. Third, we wanted to learn more about the characteristics of offenses, such as methods used to gain compliance and the relationships of the offenders to their victims. Fourth, we wanted to explore the roles played by delinquent behavior and substance abuse in juvenile sexual offending. Finally, while there is some evidence that youth respond more truthfully to paper-and-pencil instruments than to face-to-face interviews, we wanted to begin assessing truthfulness of responding and willingness to report various inappropriate behaviors, both sexual and nonsexual.

Description of Sample

The final sample contained 485 males between 11 and 18 years old. Over half were Caucasian, nearly a quarter were African American, about 10% were Hispanic, and about 10% were Asian, American Indian, or from another racial group. Most boys were assessed in treatment centers or in the offices of clinicians. Most participants had at least completed the eighth grade. Over half lived in homes owned by their parents and they came from a variety of socioeconomic backgrounds. Nearly 30% had parents engaged in skilled labor (such as carpenter, painter, fireman), about a quarter had parents who made a living through unskilled labor (such as factory worker, gas station attendant, waitress), nearly 20% of the sample had parents who were professionals (such as doctor, lawyer, teacher), and about 10% each had parents who owned their own businesses or were unemployed.

Procedure

As part of a larger evaluation, subjects completed the Abel Questionnaire for Boys. This questionnaire is comprised of four sections and asks questions regarding demographics, "normal" sexual experiences, delinquent behaviors, substance use, paraphilic sexual behaviors, sexual victimization of the participant, reported arousal to sexual vignettes, and social desirability. Social desirability questions measure the juvenile's willingness to admit to violations of common social mores and includes questions such as: "Sometimes I talk about people behind their backs," "I always admit when I am wrong," and "I would never use another person's stuff without asking them."

Traditionally, both scholars and the public have viewed sexually abusive behavior as the domain of adult males.

Characteristics of Victims and Offenses

In this sample, child molestation was the most commonly reported sexually deviant behavior; over 60% of the JSOs assessed had engaged in child molestation. Other commonly reported behaviors were pornography and fetishism, each reported by over a quarter of the JSOs, voyeurism (peeping), obscene phone calls, unwanted touching/rubbing (including rape), and phone sex, each reported by between 15 and 20% of JSOs, and exhibitionism, reported by over 10% of the JSOs.

The mean ages of onset for all behaviors were between nine and twelve. This is considerably younger than what has previously been reported in the literature. Overall, those engaging in hands-off offenses had a higher average number of acts than those engaging in hands-on offenses. Child molesters reported fewer victims than those engaging in voyeurism, exhibitionism, and unwanted rubbing or touching. However, since beginning molesting children at age 11, child molesters had engaged in about 11 acts of child molestation with over four victims. It is

important to note that upon identification, JSOs across all categories of behaviors are likely to have committed several offenses with several victims.

Comparison with Adults

When compared with a sample of adults, assessed on a similar questionnaire, juveniles reported higher frequencies for fetishism, obscene phone calls, child molestation, and phone sex. Frequencies of the other behaviors did not differ between juveniles and adults.

Who Are JSOs Victimizing?

Results showed that the largest percentage of JSOs were accused of molesting boys or girls at least 3 years younger than themselves. Specifically, the most frequently reported accusations were of touching a girl (28%) or boy (24%) at least 5 year younger, followed by accusations of touching a girl (15%) or boy (10%) 3 or 4 years younger. About 10% each had been accused of touching an adult woman or female peer, and fewer than 10% were accused of touching a same age or older male. Twenty percent of the sample had never been accused of touching another person and over a quarter had never been accused of touching a child at least 3 years younger. (Note that percentages may add up to over 100% because many juveniles were accused of engaging of more than one offense.)

Of those accused of molesting a child, nearly half had molested a younger sibling, about a third had molested another family member, and about a third had molested a non-family member who they knew. It is noteworthy that fewer than 10% reported offending against a stranger. In gaining compliance from a younger child, a quarter of the subjects indicated that they had given the child gifts, such as candy or money, and about 30% had tricked the child. Behaviors such as threats and physical force were uncommon, occurring each in 10% or fewer of the cases. Almost half of the JSOs claimed that the behavior was either mutual or initiated by the younger child.

Juveniles who had never been accused of touching a child at least 3 years younger were asked if they ever had, in fact, touched a much younger child. Nearly half responded in the affirmative. This demonstrates that many juveniles accused of sexual acting out are also engaging in other serious behaviors that go undetected. It highlights the importance of thoroughly assessing juveniles who have engaged in inappropriate sexual behaviors for other inappropriate sexual behaviors other than the offense of which they have been accused.

Antisocial Behaviors

Next, we wanted to see if juvenile sexual offending occurred as part of a general pattern of delinquent behavior and substance abuse. JSOs were asked about delinquent behaviors of both themselves and their friends. With the exception of belonging to gangs and quitting school, JSOs reported engaging in higher levels of antisocial behaviors than their friends. Only 15% indicated that they had not engaged in any antisocial behaviors. Nearly 70% had engaged in fighting, over half reported stealing, and over a quarter had each beat someone up or carried a knife or gun. Other juvenile offenders admitted to robbing people and belonging to gangs. Interestingly, rates of substance use were low. Alcohol use was evenly split between those who had never tried alcohol, those who reported some use, and those who had used alcohol on over 10 occasions. A quarter of the sample had used marijuana over 10 times, but over half had never tried marijuana, and 90% or higher had never tried any other drugs. This shows that while juvenile sexual offending may be related to an antisocial lifestyle, substance abuse does not appear to play a major role.

Truthfulness in Responding

Two methods were used to assess truthfulness in responding. First, juveniles were asked on two separate occasions to indicate how truthful they had been in responding. Second, a social desirability scale was incorporated into the questionnaire to see how willing they were to report violations of social mores and whether this related to reporting of sexually deviant behaviors.

The percentage of JSOs who reported engaging in various sexual behaviors differed based on whether they scored low, medium, or high on the social desirability scale. For all categories of behavior, participants who scored low on the social desirability scale reported a higher frequency of paraphilic behaviors than those who scored in the medium range of social desirability. Those scoring in the medium range of social desirability in turn reported a greater frequency of all behaviors than those scoring high in social desirability. This indicates that those attempting to portray themselves in a perceived socially desirable manner may be less willing to admit to behaviors, including sexual behaviors that are less acceptable in our society.

On identification, JSOs are likely to have committed several offenses with several victims.

While nearly all respondents indicated that they had been fairly to completely honest, those with higher social desirability scores claimed to have been more honest in responding than did those with lower social desirability scores. These findings show the importance of examining socially desirable responding when examining juveniles accused of sexually acting out. Evaluations of this population must take into account socially desirable responding and either denying or minimizing behavior even when claiming to be completely honest.

Summary and Discussion

In this study, the self-reported characteristics of a large sample of juvenile sex offenders from throughout the United States were obtained using a standardized evaluation. Results show that juvenile sexual offending is a problem that needs to be taken very seriously. Consistent with previous research, juveniles engage in both hands-on and hands-off offenses. Specifically, juveniles report engaging in the full range of deviant sexual behaviors reported by adult offenders, with molestation of children as the most commonly reported offense. On identification, JSOs are likely to have committed several offenses with several victims. As shown in other studies, victims are typically known to the offenders, and coercion, rather than force, is used to gain compliance.

All behaviors had an average age of onset that preceded adolescence, which is earlier than reported in other studies. It is possible that researchers, like clinicians, are hesitant to believe that deviant sexual behaviors can be committed by this age group and therefore do not assess for such behaviors. However, this discrepancy may be the result of the fact that most information on juvenile offenders comes from retrospective reports of adult offenders. To date, it is unknown whether these early-onset juveniles grow up into adult offenders. Some evidence suggests that they may actually grow up and engage in a wide array of antisocial behaviors, rather than specifically sexually reoffending.

Data in this study show that presenting oneself in a socially desirable manner is related to the number of behaviors

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reported. This points to the importance of assessing social desirability and of not relying solely on self-report in evaluating juvenile offenders. It is important to anchor self-report information with as many other sources of information as possible, including police and victim reports and more objective measures of sexual interest and arousal. This study only used self-report information. Further, adolescents generally do not self refer for treatment, especially for behaviors that are often illegal. Behaviors described in this study are therefore likely to be an under- estimate of what is occurring. They are descriptive of those behaviors reported on a questionnaire by juveniles who have likely been caught and sent for an evaluation, not an accurate picture of what juvenile offenders are actually doing.

This study demonstrates the importance of taking reports of deviant sexual of deviant sexual behaviors very seriously, even among preadolescents, in order to prevent future offending. However, future research must begin to identify the factors that predispose young children and adolescents to sexual offending and identify the warning signs and risk factors for such behavior so that intervention programs can be developed and appropriate youth targeted. ∴

Stacey C. Zolondek, M.A., is a clinical psychology graduate student at Emory University and is current doing her predoctoral internship at Brown University. Gene G. Abel, M.D., is a professor of clinical psychiatry at Emory University School of Medicine and Morehouse School of Medicine in Atlanta, Georgia. William F. Northey, Jr., Ph.D., is a marriage and family therapists and the research specialist for the American Association for Marriage and Family Therapy in Washington, D.C. Alan D. Jordan, B.A., is a statistical analyst at Abel Screening Institute in Atlanta, Georgia.

This article is condensed from S.C. Zolondek, G.G. Abel, W.F. Northey, and A.D. Jordan, (2001). The Self-Reported Behaviors of Juvenile Sexual Offenders. *Journal of Interpersonal Violence*, 16(1), 73-85. Copyright © 2001 by Sage Publications. Reprinted by Permission of Sage Publications. All rights reserved.

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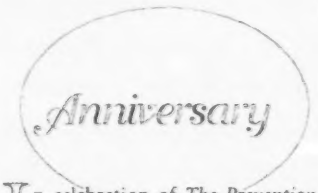

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Lesbian, Gay, and Bisexual Youth Q&A

with Caitlin Ryan, M.S.W., A.C.S.W. and Donna Futterman, M.D.

Editor's Note: We would like to thank Caitlin Ryan, M.S.W., and Donna Futterman, M.D., authors of *Lesbian & Gay Youth: Care & Counseling* (Columbia University Press) for participating in the following Q&A session. The following questions were posed by you, our readers, via our Web site <www.TPRonline.org>.

Q: What is the correct language? It seems like it's always changing. We're afraid of being insensitive to youth we serve who are LGBT.

A: Sensitivity to how youth define and label themselves is important since it signals that you are knowledgeable and responsive in addressing their needs and concerns. Non-heterosexual youth often resist labels and, increasingly, many youth are not comfortable self-labeling as lesbian or gay. Many non-heterosexual youth also identify as bisexual but since no research has been published on adolescent bisexual identity it's unclear if that's a stable identity which is actually consolidated during adolescence. Labels are salient for practice, however, since they signal a range of experiences and potential risks for providers to address. For example, several studies have shown additional vulnerability for bisexual youth, including sexual health risks and multiple suicide attempts.

One direct way to avoid being insensitive is to ask youth how they self-identify and what language they would prefer you to use. Many young people, particularly those who are connected through the internet and LGBT support groups, self-identify as queer, a label that expresses their non-heterosexual status in a way that celebrates difference. While this label works for many youth, particularly in large urban areas, it is not used by many youth of color, especially African-Americans. An internet survey of people who use a Web site for LGBT youth found many labels for adolescent users, including not wanting to be labeled at all. These labels will continue to change as they have with non-heterosexual adults since the early 1900s. Ask your LGBT adolescent clients, check out publications for non-heterosexual youth, and visit their Web sites to see how they are self-labeling.

Q: What are the first pieces of information or the first things you do when working with clients who come out?

A: Ask if they have any questions about sexual orientation, assess their level of adjustment and distress and determine if they have any immediate concerns. If they do, address them first. Many youth have misconceptions about their sexual identity, particularly as it relates to risk. Ask how long they have known and when they decided they were LGBT. Ask who else has been told and how they reacted. Make sure that youth have access to local resources and basic information. Ask about their exposure to other gay people, such as an older gay relative or family friend. (Exposure to positive gay role models in childhood is an important source of resiliency in gay adults and can help youth understand and accept their emerging sexual orientation.) Ask if they have any LGBT friends, have accessed LGBT Web sites, or are connected with LGBT community groups. Online resources are especially helpful for youth in smaller towns that lack LGBT youth social and recreational organizations (see Web Resources on page 6). Participating in LGBT youth organizations provides normative opportunities to express their emerging LGBT identities, learn about gay culture, and socialize with other LGBT youth.

Ask if their parents know or suspect that they may be gay and help the youth develop a plan should their parents learn about their sexual orientation from others. Coming out to parents requires careful thought and planning since most parents are distressed when learning that their child is gay and some may react violently (see the next question for more information on coming out to parents). Identify any immediate needs and make appropriate referrals (e.g., counseling). Always ensure that you assess referral sources for their experience, knowledge and sensitivity to LGBT issues before referring a client to them.

In a recent study, many LGBT youth who came out to family members reported verbal and physical abuse from parents and siblings.

Q: I recently had a youth come out to me as being gay. We live in a small town and I know his parents do not know. How do I approach this subject with them?

A: I'm assuming that the youth has asked for your help in talking with his parents about his sexual identity. Confidentiality is a cornerstone of adolescent care and, as providers, we are bound to protect our patients' and clients' confidentiality unless the information they disclose is harmful to themselves or others. This means not disclosing a patient's sexual orientation to others, including parents, unless we are asked to help them do so.

Coming out to parents should not be done hastily. An adolescent who self-identifies as lesbian, gay, or bisexual has been thinking about his or her sexual orientation for some time (generally for

(Continued on Page 3)

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From the Editor's PC

Dear Colleague,

Welcome to our annual Resource Issue, a supplement to the quarterly *Prevention Researcher*. This year we focus on the topics of depression, alcohol, eating disorders, homeless youth, and lesbian, gay, and bisexual youth. We believe this year's issue, in particular, is truly a resource "gem" thanks to the contributions of many people.

We would like to thank Caitlin Ryan, M.S.W., from San Francisco State University and Donna Futterman, M.D., from Albert Einstein College of Medicine for participating in this year's Q&A feature focusing on lesbian, gay, bisexual, and transgender youth.

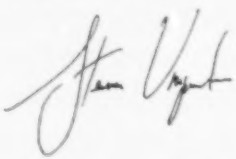
We would also like to thank Randa Ryan, Ph.D., for the insightful interview on eating disorders and athletes. Dr. Ryan, from the University of Texas at Austin, has been studying this issue, working with student athletes, and writing about the serious consequences of eating disorders for over 20 years.

Also participating in an interview is Terrie Lyons, Ph.D., a psychologist and trauma response specialist who has been involved with the Red Cross for a number of years. Dr. Lyons volunteered to assist the mental health community in New York City in the weeks following the September 11 attacks.

Many people contributed to our book reviews. We would like to thank Joel Bergstedt and Karen Jones, Ph.D., from the University of Georgia; Jami Finkelson, Ph.D., from Columbia University; John de Miranda, Ed.M., a member of our Editorial Board and Executive Director of the National Association on Alcohol, Drugs, and Disability; and Ray Tricker, Ph.D., from Oregon State University, for taking the time to write insightful book reviews.

This year we also introduce a new feature that we have titled "From the Inside." This feature spotlights real-life success stories written by our readers. We would like to thank everyone who submitted stories. This year, we look at the success of the STARS program in Waco, Texas, in an article written by Olga Vaca Durr, M.Ed.

All the best in 2003,



Steven Ungerleider, Ph.D.
Psychologist/Editor

The Prevention Researcher

The Prevention Researcher is a quarterly newsletter that acts as an intermediary between researchers and service professionals. Established in 1994, *The Prevention Researcher* publishes professional articles based on the latest research. Each single-theme issue focuses on an at-risk youth topic from a prevention standpoint. *The Prevention Researcher* is indexed in ERIC and CINAHL.

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Recycled Paper

several years), but for many parents, this comes as a shock. Sexual identity disclosure often precipitates a family crisis and parents need accurate information and support to sort out their feelings, integrate this new information, and provide appropriate support and guidance for their LGBT adolescent.

Many youth today choose to come out to their parents since hiding and compartmentalizing their identity is very stressful and constricts the parent-child relationship. However, they should think this decision through carefully. Providers can help them weigh the pros and cons and identify available resources ahead of time so their parents have knowledgeable resources to turn to for information and support. Youth who come out feel more comfortable with themselves and have greater access to supportive resources, however, they are also at higher risk for victimization at home and school settings. In a recent study, many LGBT youth who came out to family members reported verbal and physical abuse from parents and siblings and some were ejected from their homes.

After helping an adolescent think about the repercussions of coming out to parents and planning for potential reactions, you may decide together that the best approach is for you to help tell them. Have a list of resources on hand, including articles, books, contact information for the nearest PFLAG (Parents, Families and Friends of Lesbians and Gays) chapter and a referral for a knowledgeable family counselor. Since many parents turn to their pediatrician, family physician or other medical provider first after a child comes out, your involvement can help them assimilate this new and often confusing information. Parents need time to adjust, to grieve the loss of their dreams and expectations for their child, to reframe stereotypes and misconceptions about homosexuality and to develop new expectations and life goals for their lesbian, gay, or bisexual child.

PFLAG is a national organization with chapters (usually several) in every state that provides education and support for families and friends of LGBT persons, and advocacy on these issues. Contact information for chapters is available online at <www.pflag.org> or by calling the PFLAG national office at 202-467-8180. Chapters are staffed by parents who can provide immediate support and accurate information including reading lists on sexual orientation and family dynamics. Many chapters have support groups for parents and LGBT adolescents, and can provide referrals for family counselors and mental health providers who are knowledgeable about LGBT issues.

Q: As counselor at a middle school, I often struggle with the issue of presenting myself as an ally and making it safe for students to consider coming out to themselves and/or to me. I do not want to rush or force an issue of orientation, but sometimes that issue is prominent in my concerns for their well-being. How can I help without outing them to themselves or scaring them by outing them to me? I have the "I'm willing to talk about…" poster from GLSEN (Gay, Lesbian, and Straight Education Network) on my wall and a Safe Space pink triangle sticker on my door.

A: Providing an accepting, supportive environment where youth feel safe to disclose any concerns they might have is the most basic component in encouraging them to open up when they're ready. Talking about these issues is more difficult for some youth given their religious and cultural backgrounds. Most children have internalized very negative stereotypes of homosexuality and these misperceptions make it hard to self-identify as lesbian or gay. Displaying the GLSEN poster and Safe Space sticker signal your willingness and sensitivity in addressing these issues. Youth may feel alarmed if adults are too direct in asking about issues that may be emotionally charged. Generally, youth will discuss these concerns when they're ready to do so. If you have a supportive relationship or are known as a trustworthy listener, they will talk about these issues with you. If you have a concern about a particular student, you might use school-related events such as an anti-gay harassment incident, as an opener to talk about his or her feelings about these issues. Introducing the topic obliquely lets the youth know that you are aware of these concerns, are sensitive to them, and are someone who can be turned to for support. Since studies show that youth, on average, become aware of same-sex feelings at age 10, it's important for counselors and other middle school-based practitioners to be observant and prepared to address sexual identity issues with students and parents.

Lesbian, gay, bisexual and, often, transgender youth are present in our programs and agencies but generally don't come out unless it feels safe to do so.

Q: How can we make our teen program a safe place for LGBT youth?

A: There are several steps any program can take to create a safe and welcoming environment for LGBT youth. Lesbian, gay, bisexual and, often, transgender youth are present in our programs and agencies but generally don't come out unless it feels safe to do so. Creating a supportive environment will let all youth know that they can talk about sensitive issues, including substance abuse, family violence, and sexual abuse, as well as sexual and gender identity.

1) Develop a policy on caring for LGBT youth. Engage both frontline staff and administrators in discussing what needs to change to increase provider's comfort level in serving LGBT youth. Include outreach, staff training, visibility, and referrals in your policy and revisit it as needs change. Address the needs of transgender youth such as using appropriate pronouns to increase an adolescent's comfort level and designating a unisex bathroom to avoid conflict and humiliation when others misperceive an adolescent's gender.

2) Provide initial and ongoing staff training. Although new information and research is continually published on LGBT youth, many agencies that provide staff training only offer a one-time training on LGBT issues, so recent research that affects care is generally not disseminated. This leaves inaccurate or outmoded information to guide practice. Provide regular updates to enable staff to discuss new data and emerging issues. Check out the American Psychological Association's Healthy Lesbian, Gay and Bisexual Students Project <www.apa.org/ed/hlgb> for a searchable database of professional literature on health and mental health concerns.

3) Demonstrate that LGBT youth are welcome. Mention LGBT youth in literature and program brochures when discussing target populations for your services. Include posters, pamphlets, and books that address LGBT issues in waiting rooms and offices. An excellent all-purpose poster on many adolescent concerns "This is a safe place to talk about..." is distributed by the Wildflower Resource Network and is available online at <www.wrnetwork.net>. Include LGBT youth as members of

youth advisory boards, and regularly elicit feedback from LGBT and other adolescent patients about access, quality of care, and provider's cultural competency. Use adolescents' feedback to inform your practice. And do outreach to LGBT youth services and other organizations that serve LGBT youth in your community to let them know that your agency is sensitive to their needs and concerns and welcomes them as clients and patients.

Q: What would make a support or educational group inviting for homeless gay and lesbian youth?

A: Many LGBT youth are homeless as a result of family conflict and running away or being forced out of their homes. Homeless youth are at high risk for exploitation, HIV, STDs, unintended pregnancy, mental health problems, violence, and victimization. Many cities have a dearth of services for homeless youth so making existing services more welcoming and responsive to their needs is especially important. There are several ways to do this. Make sure that outreach workers include homeless youth in their routine outreach activities since this lets them know that they are welcome in your program. Homeless youth will feel more comfortable dropping into programs when someone they know from the street has invited them. Tell them that your program is LGBT youth-friendly and that food and basic hygiene supplies will be provided. Food, in particular, is a big incentive in welcoming street youth. Sandwiches or other wrapped food that's easy to carry will enable them to take some when they leave. Provide some basic toiletries, such as razors, small motel soap bars, shampoo, towelettes, condoms, and information on health services, such as street clinics and HIV counseling and testing programs.

All youth should receive counseling on HIV-related risks.

Meeting basic needs while providing other services is the most direct way of ensuring that homeless youth will participate, and a large proportion of them will be LGBT. If you specifically want to target LGBT homeless youth, street outreach workers can talk about your program's aims and sensitivity, but food and hygiene supplies will encourage them to come and to come back again. On the street, candy is a big ice breaker and it's an immediate way to get their attention when you talk about your program. Once your program is known as a supportive environment where they can eat, socialize and take a break from the streets, these youth will drop by.

Q: How can I work with gay and lesbian youth who come from strong religious backgrounds?

A: Lesbian and gay youth from strong religious backgrounds, particularly those that consider homosexuality to be sinful, have more difficulty integrating and accepting their sexual identity than youth from more tolerant religious backgrounds. Fundamentalists are more likely to have negative attitudes about gay people than those with other religious views. And evangelicals are more than twice as likely as others to believe that homosexuality is a chosen lifestyle (rather than innate) which affects their attitudes about sexual orientation. LGBT youth from religious traditions with negative beliefs about homosexuality have generally internalized these views and see themselves as sinful. Providing referrals to sensitive clergy as an adjunct to counseling can help youth begin to understand and cognitively address the contradictions between their religious training and their sexual identity. Another important resource is lesbian and gay religious organizations (such as Lutherans Concerned, Dignity [Catholics], Rainbow Baptists, and More Light Presbyterians), that have Web pages, publications and often, local religious services to help gay people celebrate their religious traditions without compartmentalizing their sexual orientation. A list of many of these resources is available online at <www.mlp.org/resources/ecu.html>. Integrating their sexual identity and religious backgrounds is extremely stressful for youth, and can take a long period of time. Providing support, access to community resources, books, and referrals to sensitive clergy can help them connect these very important areas of their lives.

Q: Our teen program has on-site HIV testing and counseling. Is the referral for services perceived as stereotyping gay behavior and an insensitive referral if they are not presenting with more than one risk behavior? Are we seen as stereotyping and making assumptions that they are sexually active?

A: Given the increasing rates of HIV infection in adolescents, all youth should receive counseling on HIV-related risks. The counseling process enables providers to assess an adolescent's risks, and decide if HIV testing is warranted. When initially asked, some youth deny being sexually active, yet later test positive for pregnancy or STDs. If you use counseling as a means to assess risks for all youth, it's not insensitive to refer some for HIV testing.

Q: How can we increase non-LGBT youths' sensitivity and understanding of LGBT issues?

A: One approach is to focus on adolescents' capacity for empathy, reminding them that each person is an individual and wants to be respected for who he or she is. Most studies show that homosexuality, like being left-handed, is not a choice. By reminding youth that everyone has some experience, characteristic, or trait about which they're unsure how others may react, we can try to connect with their sense of fairness and empathy. It helps to encourage adolescents to connect with the experience of LGBT youth: how would they feel having a characteristic (like left-handedness) that is a basic part of their being and can't be changed? And what if that characteristic were perceived very negatively so they had to hide it, even from their parents, family members and their closest friends? Helping youth personalize the experiences of LGBT youth can help them understand the level of isolation, fear of disclosure and anxiety that LGBT youth experience. Most will find the victimization that LGBT youth are faced with to be unfair and unacceptable. Fairness is a basic American value, which is why most Americans disagree with lack of employment protections based on sexual orientation. Fairness is also an important value for adolescents and a way to teach them respect for differences.

Caitlin Ryan, M.S.W., A.C.S.W., is Director of Policy Studies, Institute on Sexuality, Inequality and Health, San Francisco State University. Donna Futterman, M.D., is associate professor of Pediatrics at Albert Einstein College of Medicine and Director of the Adolescent AIDS Program at Montefiore Medical Center. They have authored articles for *The Prevention Researcher*, and are authors of the book *Lesbian & Gay Youth: Care & Counseling* (Columbia University Press).

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From the Inside

STARS High School

By Olga Vaca Durr, M.Ed.

High school dropouts are a growing concern throughout the United States. So much so that the issue has been included in the Goals 2000: Educate America Act and the No Child Left Behind Act. Some students drop out to help support their families, others are starting their own families as teenagers, while others are experiencing academic problems, attendance problems, or behavior problems and feel the need to drop out prior to obtaining their diploma.

In an effort to combat dropout rates twice the state average, the Waco Independent School District in Waco, Texas opened STARS High School. STARS stands for Students That Are Reaching Success, and that is just what they are doing! The school is an alternative, academic-type high school which meets at alternative hours compared to the normal 7:30 a.m. – 3:30 p.m. school day, thus, meeting the needs of working students who want to continue their education. The philosophy behind the school is based on the "Contextual Learning" approach to education, where the content is related to past experiences of the learner. This is coupled with "Choice Theory," developed by Dr. William Glaser, which provides an atmosphere and approach where students realize they are responsible for the choices they make and these choices are what enable them to experience success. As a result, the students come to realize the need to arrive prepared and get involved with their academic experiences on an individual basis to reach their first goal — receiving their high school diploma.

The school opened in January 2002 with 42 students and by the beginning of summer session 78 students were enrolled, with many more on the waiting list and new students calling everyday. The district goal is to serve 150-170 students during a three session day, starting Fall 2002.

Not a day goes by that someone is not awed by the success in this school; from the students, to the teachers, and even the principal himself. Each one has his or her own story and each story gets to you. Some students arrive straight from work, some in a cab or walking from the other side of town in 100-degree heat; but they all get there on time. If there is a chance they might be a little late, they make sure to call first.

When a visitor enters the classroom, the first thing he or she notices is that everyone is eager to be there. Students arrive, sign in and get to work. No one has to remind them to get out their work or to get started. And a mention as to what page to turn to or to quiet down is rarely ever heard. By sitting and talking with some of the students, one learns how amazing they are. A visitor might meet the 20-year-old mother who dropped out after feeling too overwhelmed to deal with the pressures of being a parent and student at the same time. When you ask her why she came back she will tell you, "I want to do more for my daughter than my mother did for me." This student gets up everyday at 5:00 a.m. and works from 6:00 a.m. – 2:00 p.m. After work she walks home, spends a few hours with her daughter and then walks to school. She attends school from 5:00 p.m. – 9:00 p.m. and then walks home to start her routine over.

As you continue to walk throughout the room, you might meet another student who experienced a tragic death in his family. As a result, his grades began to reach an all-time low and he eventually got in trouble with the law. Ultimately, he phased out of active life in the traditional school setting and one day happened upon STARS High School. Not only did he enroll, he also walked across the stage straight to college. With one successful graduation behind him, he is now focused on a career in auto technology.

By talking with the students, visitors will find the reason many of them dropped out is because they felt the administration at the traditional school did not care. These students were in school at times when they were experiencing hardships in their lives and found no positive assistance. Not knowing how to deal with their problems, the alternative of dropping out appealed to them as the easiest way out.

When talking to these students about their experiences at STARS High School, they will say "the staff cared about me and followed up on me on a daily basis," or "the focus was on me as an individual and my individual academic needs." The students even feel the course work is finally beginning to make sense and is meaningful to what they are trying to accomplish in "the real world." Some of the students that have already graduated have proudly come back to say that since they have graduated they have received a raise or promotion from their jobs. All this was made possible due to the fact they are now classified as high school graduates and have a high school diploma.

Visitors will also quickly notice how amazing the teacher and the principal who work with these students are. The teacher is one of those who loves teaching, and she teaches morning, noon and night (and surely even in her dreams)! She is always there to provide assistance and add a caring smile or hug, whichever is needed. The principal looks like an ex-defensive lineman, but appearances can be deceiving. As soon as he starts to talk, his love for his job and these students is noticeable. He is waiting for students to take the first step of being responsible for their own actions, and enrolling in the school. He conferences with each student individually regarding the expectations and how many more credits they need to finish. He is there daily, being a role model, a support unit, and the administrator that finally cares about them. If students are absent, he calls them personally, not leaving it for a secretary or counselor to tend to.

The atmosphere is so positive at STARS High School, there is no wonder why students are succeeding semester after semester! And they are indeed succeeding. ~

Special acknowledgment and thanks are given to Dr. John Reiher, principal of STARS High School, for his contributions and input in writing this article.

Olga Vaca Durr, M.Ed., is the School Completion Specialist for the Waco Independent School District. She has worked in education for nine years as a teacher, Bilingual Educational Diagnostician, and Administrator. Ms. Vaca Durr has started her Doctorate at Texas A&M University.

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"From the Inside" is a new annual feature of *The Prevention Researcher*. It is our goal to share real-life, positive stories about working with youth. We encourage submissions from anyone, including youth. For more information, see the submission guidelines on our Web site at www.TPRonline.org or e-mail us at CKimball@TPRonline.org.

Web Resources

There is a large amount of information available on the World Wide Web. We list these Web sites only as possible starting points on your journey. The Prevention Researcher *does not control the information presented on these sites and makes no claim as to the accuracy of the content. These descriptions and URLs were correct when we went to press; however due to the nature of the Internet, we make no claim to their future content. Inclusion in this list is not an endorsement by* The Prevention Researcher *or its publisher, Integrated Research Services, Inc.*

Alcohol

National Center on Addiction and Substance Abuse at Columbia University
www.casacolumbia.org

The mission of the National Center on Addiction and Substance Abuse (CASA) is to "inform Americans about the economic and social costs of substance abuse." CASA offers a number of publications for free in PDF format. These include such titles as "Teen Tipplers: America's Underage Drinking Epidemic," "Substance Use and Risky Sexual Behavior Fact Sheet," and "Malignant Neglect: Substance Abuse and America's Schools." Also included is an extensive list of links (grouped by type), and information about specific CASA programs.

Prevline: Prevention Online
www.health.org

From the U.S. Department of Health and Human Services, Prevline provides information about different types of drugs, and the people who use them. There are a number of resources here regarding teens and alcohol including "The NHSDA Report: Low Rates of Alcohol Use Among Asian Youths," "Alcohol Use Among Girls," "The NHSDA Report: Binge Drinking Among Underage Persons," and "Alcohol Alert No. 37: Youth Drinking: Risk Factors and Consequences."

Safety First
www.safety1st.org

Safety First is a project of the Drug Policy Alliance. Safety First uses the harm reduction approach to address adolescent alcohol and other drug use. According to the founder, Marsha Rosenbaum, Ph.D., "while we stress the value of abstinence, we need a fallback strategy for those youth who still say 'maybe' or 'sometimes' or 'yes' to drugs. We need a strategy that embraces safety as its bottom line." This Web site includes information for parents and schools and access to the brochure "Safety First: A Reality-Based Approach to Teens, Drugs, and Drug Education."

Athlete's Substance Use

Choices in Sport
www.drugfreesport.com/choices

The Choices in Sport Web site is designed by the NCAA and, as such, is focused on collegiate athletics. This site provides information on a variety of drugs and their effects on athletes, the psychology of sport, and sport nutrition. The unique aspect of this site is that it not only includes separate areas for athletes and coaches, but also an area for crew chiefs, athletic trainers, and team physicians.

NCAA Educational Programs and Information: Drugs and Alcohol
www.ncaa.org/sports_sciences/education

This Web site is a gateway to numerous resources on athletes and drug use, including spit tobacco, alcohol, and steroids. Also included are links to the bi-annual NCAA Sports Sciences Education Newsletters. This Web site is by the National Collegiate Athletic Association so all information is geared to college athletes.

Depression

Depression – Children and Adolescents
www.nimh.nih.gov/publicat/depchildmenu.cfm

This site is a gateway to resources provided by the National Institute of Mental Health. It provides access to several documents and fact sheets produced by the government, including "What to Do When a Friend Is Depressed," "Stories of Depression: Does This Sound Like You?," and "Depression in Children and Adolescents: A Fact Sheet for Physicians."

There is Help
www.thereishelp.org

From the Centre for Addiction and Mental Health, this is a comprehensive, attractive, informative site with information about types of depression, what to do if you know someone who is depressed, types of treatment, and much more.

Dropout Prevention

Hispanic Dropout Project
www.ncela.gwu.edu/miscpubs/hdp

According to the Web site, "the Hispanic Dropout Project's mission is to shed light on this national crisis, to produce concrete analyses and syntheses, and to recommend actions that can be taken at all levels in order to reduce the nation's dropout rate of Hispanic youth." There are a variety of reports on this site including *"Transforming Education for Hispanic Youth: Exemplary Practices, Programs, and Schools," "No More Excuses: The Final Report of the Hispanic Dropout Project,"* and *"Effective Programs for Latino Students in Elementary and Middle Schools,"* among many others.

Operation Graduation
www.operationgraduation.com

By the Ad Council, Operation Graduation is targeted to young people. This Web site includes links to resources for mentoring programs, homework help, cultural and community groups for support and information, online help and crisis lines, and information about issues affecting youth. Also included are resources for studying for college exams and applying for financial aid.

Eating Disorders

Center for Change
www.centerforchange.com

The Center for Change is a treatment facility for people with eating disorders. Their Web site includes a number of free resources, mostly in the form of articles written by center staff. The articles on this site go beyond the basic definitions, signs and symptoms, and treatment options that many other Web sites provide.

Harvard Eating Disorders Center
www.hedc.org

The Harvard Eating Disorders Center is an academic research center which is affiliated with Harvard Medical School. Besides information which defines eating disorders and discusses medical complications, this site also includes information specifically for teachers, parents, and friends.

National Eating Disorders Association
www.nationaleatingdisorders.org

The National Eating Disorders Association was created in 2001 when Eating Disorders Awareness & Prevention (EDAP) joined forces with the American Anorexia Bulimia Association (AABA). Their mission is to eliminate eating disorders and body dissatisfaction. This Web site includes information for parents, friends, coaches, athletes, boys, girls, men, and women.

Homeless Youth

International HOMELESS Discussion List, Archives, and Weblinks
csf.colorado.edu/homeless

This Web site is a "megasite" of links to other resources which deal with homelessness, including a number of links to sites on adolescent homelessness. Despite its "low tech" feel, this site appears to be well maintained as all the links were active during our latest visit.

National Center for Homeless Education at SERVE
www.serve.org/nche

The National Center for Homeless Education at SERVE is funded by the U.S. Department of Education. The mission of NCHE is to "be a national resource center of research and information enabling communities to successfully address the needs of homeless children and youth and their families." This site includes information about the McKinney-Vento Legislation, current McKinney-Vento Programs (listed by state), contact information for the Coordinators of Education for Homeless Children and Youth for each state, an extensive list of links to other online resources, and information on numerous topics related to homelessness.

Raising the Roof
www.raisingtheroof.org

Raising the Roof is a Canadian charity dedicated to long-term solutions for homelessness. This Web site includes a database of over 400 programs in housing, health, employment, education, finance, the legal sector and criminal justice, and child welfare. These programs are located primarily in Canada and the U.S. Also included are in-depth case studies of 50 programs giving a background, goals and objectives, approach, outcomes, contact information and more.

Internet Resources

MINCAVA (Minnesota Center Against Violence and Abuse)
www.mincava.umn.edu

The mission of MINCAVA is to support research, education, and access to violence related resources. This Web site is a clearinghouse of electronic resources covering all forms of violence, including (but not limited to) dating violence, hate crimes, gang violence, school violence, sexual violence, domestic violence, youth violence, and survivor resources.

National Youth Violence Prevention Resource Center
www.safeyouth.org

The National Youth Violence Prevention Resource Center is sponsored by the Centers for Disease Control and Prevention and the Federal Working Group on Youth Violence. It includes links to resources grouped by topic. All links appear to be to government Web sites or national organizations. Also included are a number of "hot topics" with fact sheets and additional resources for each topic, an extensive calendar of events, and a vast number of publications available for download.

Youthwork
www.youthwork.com

The Youthwork site has a couple of nice features. The first is a list of links to other sites, grouped by topic. All links are annotated, and sources include the federal government, organizations, and private individuals. The second is an ever-growing list of activities to do with youth. The activities are divided into "warm up" activities, problem solving, dividing into small groups, and "general." Other features include stories submitted by youth and adults, and links for youth. Forms for submitting new sites, stories, or activities are prominently displayed so this site has the continual potential to grow.

Lesbian, Gay and Bisexual Youth

Advocates for Youth
www.advocatesforyouth.org/glbtq.htm

The Advocates for Youth Web site provides information for both adults working with LGBT youth and youth themselves. Besides a number of publications for adults and pamphlets for teens, this site provides access to Youth Resource, a comprehensive Web page with information on health concerns, religion, youth of color, rural youth, transgender youth, and peer support. There is also access to a listing of LGBT youth groups across the nation. Youth Resource can be directly accessed at <www.youthresource.com>.

Gay, Lesbian, and Straight Education Network
www.glsen.org

This site provides information on creating safer schools, starting a Gay-Straight Alliance (GSA) in local schools, finding local chapters, and finding GSAs in schools throughout the country.

Healthy LGB Students
www.apa.org/ed/hlgb

The mission of the Healthy Lesbian, Gay and Bisexual Students project by the American Psychological Association is to "strengthen the capacity of the nation's schools to prevent the behavioral health risks of lesbian, gay, and bisexual students through knowledge development, dissemination, and application, working with and through national organizations of school stakeholders." The project is the result of a collaboration between six national organizations representing school counselors, school nurses, school psychologists, and school social workers. This Web site includes recent news relating to the health of LGB students, e-mail listservs for the above groups for the purpose of discussing healthy LGB issues, and a searchable database of over 300 journal articles, book chapters, and other publications relevant to this topic.

SIGNS: School Survival Guide for Lesbian, Gay, Bisexual, Transgendered, Questioning Youth and Their Allies
www.centeryes.org

SIGNS is a project of high school students in the Youth Enrichment Services Program of the Lesbian, Gay, Bisexual, and Transgender Community Center in New York City. This Web site is intended for other lesbian, gay, bisexual, and transgendered youth. It includes such resources as how to start a Gay-Straight Alliance, what to do if a youth is experiencing violence, stories from youth from around the world, an "ask the experts" section, and a list of resources.

Youth Guardian Services
www.youth-guard.org

This site provides peer-supervised online support through listservs, separated by age, with groups for youth ages 13–17, 17–21, and 21–25, and another list for youth who have an LGBT family member.

The Other America: Teens with Eating Disorders

By Gail B. Stewart

Reviewed by Joel Bergstedt and Karen Jones, Ph.D.

2001. San Diego, CA: Lucent Books.
ISBN 1-56006-764-0

Gail Stewart's book, *Teens with Eating Disorders*, is part of *The Other America* series. The basic premise of the series is to provide, through a set of interviews, a more meaningful context for various societal concerns. As noted in the foreword of the text, too often problems are de-contextualized by political rhetoric. Consequently, people are grouped together based on their common problems regardless of their different circumstances. By recounting the experiences of troubled individuals, the series hopes to elicit more personal, in-depth understandings of both the consequences and the causes of a certain problem. In addition, it is presumed that the case study approach will initiate a more affective response from the reader, as he or she is able to relate and empathize with the individuals being interviewed. *Teens with Eating Disorders* succeeds in both objectives by providing salient information about eating disorders in an appropriate and diverse context.

The introduction to *Teens with Eating Disorders* states the importance of group therapy to overcoming an eating disorder. In such a format, individuals share with other affected peers their personal histories and experiences with the disorder. Hearing others' struggles and realizing that they are not alone gives each individual a feeling of comp anionship, which negates the isolation characteristic of secretive disorders. The book, while instigating public awareness, could therefore have therapeutic implications for teens with eating disorders. All of the young people interviewed by the author are now in their early twenties, and can act as peer models for other teens. Because they are older and have come to terms with their problems, the subjects are able to reflect on the development of the disorder and criticize their own misperceptions acquired during adolescence. Each individual gives his or her personal history by describing family life, experiences in school, the beginnings of his or her eating disorders, side effects, treatments received, and lessons learned. The interviewees encompass a diverse background, so most readers will be able to develop a clearer understanding of the causes of the disorder by relating personal experiences to those of the subjects. The four young adults interviewed in the book include Sherrie, Jodi, Michael, and Lani.

The first chapter or case study is devoted to Sherrie. Sherrie is a twenty-four year old college graduate, who has been obese her entire life. Although she still suffers from mild bulimia, she is now recovering. Sherrie grew up in a small town and, because of her appearance, was never accepted among her peers. The isolation she experienced in school, coupled with an unsupportive family, resulted in her negative self-concept and depression. Sherrie became bulimic when, after losing weight from a sickness, she received compliments from her family. Interspersed among her personal struggles, Sherrie describes physical effects of the disease and her various attempts at counseling. When reflecting on the causes of her condition, Sherrie now stresses the importance of a healthy self-concept as a deterrent to the development of eating disorders.

While Sherrie grew up being criticized for her appearances, Jodi, the next subject, was raised in a supportive environment. She developed anorexia, bulimia, and obsessive exercising as a result of her compulsive, controlling personality. Being extremely goal-oriented, Jodi created a model-image impossible to attain. Her compulsion to succeed led her to bulimia. She could never lose enough weight, and she ultimately lost control. Jodi describes the disease as a personal struggle, and by the end of her story, she states the importance of self-acceptance and moderation.

Michael presents a different perspective than that of the others represented in the book. While both Sherrie and Jodi touch on the secrecy of the disorder, Michael vividly describes the guilt associated with leading a dual life. He was aware of his homosexuality in early adolescence, and to compensate for his perceived deficiency and gain acceptance from peers, he adopted a defiant, self-destructive lifestyle at school, all the while maintaining his reserved demeanor at home. Unlike Sherrie and Jodi, Michael reached out to family for support in overcoming his eating disorder, and ends his story by also stressing the importance of self-acceptance.

The closing chapter of the book involves the story of Lani, a self-confident young woman who developed anorexia during college. Her disorder stemmed from a loss of confidence resulting from insinuating comments made by a boyfriend. Like Sherrie and Jodi, she kept her disorder from her family. Her frightened mother eventually demanded that she undergo testing and treatment. After recovering from anorexia, Lani realizes the importance of accepting one's self, but she also stresses that seeking and accepting support is essential to overcoming eating disorders.

As the book chronicles the passage of children into teens and young adults with eating disorders, it demonstrates how important support and positive self-perception are to the development of healthy adult lifestyles. The book shows how various circumstances during adolescence can cause the development of low self-esteem, which in turn results in the incidence of eating disorders. Each chapter not only stresses the importance of a positive self-concept to deter eating disorders among youth, but also provides the reader with information about the causes, symptoms, and treatments of the disorders. Because of the book's informative and affective characteristics, its audience is not confined to a certain segment of the population. Anyone, from students and teachers to concerned adults, would benefit from reading this book.

A brief epilogue provides readers a glimpse of the progress or struggles of the four individuals after completion of the interviews and writing of the case studies. Although this is a good summary and provides some insight into the continued success or difficulties of each person, adult family members and

health practitioners may find it helpful to develop a list of questions, activities, or reflections related to either the cases presented in *Teens with Eating Disorders* or the individual teenager who is reading the book. Since the introduction of the book addresses the importance of group therapy, the addition of activities or discussion questions may lead to productive dialogue in these settings.

A greater acceptance and understanding of societal concerns is facilitated through the explication of stories like those recounted in this book. Because these are normal people with insidious disorders, the reader connects with the subjects and empathizes with their plight. However, the title of the series seems to contradict this integrative purpose by separating the average reader from the subjects of the book. The interviewees of the series should not be classified as outsiders. Instead, subjects should be labeled as common people dealing with difficult problems. As noted by the book, the subjects all come from traditional, although different, family backgrounds, but their disorders developed from the common adolescent problem of low self-esteem. The young people described in the book are not "others," but rather are typical youths. Once our implicit commonalities are made explicit, general empathetic understanding will develop, and perhaps disorders in which people starve themselves for acceptance will stop.

The author: Gail B. Stewart is an author of more than eighty books for children and young adults. She lives in Minneapolis, Minnesota.

The reviewers: Joel Bergstedt is a graduate assistant working on a Masters of Education in Occupational Studies at the University of Georgia. Karen Jones, Ph.D., is a professor in the Occupational Studies Department at the University of Georgia.

BOOK REVIEW

Helping Students Overcome Depression and Anxiety

By Kenneth W. Merrell, Ph.D.
Reviewed by Jami Finkelson, Ph.D.

2001. New York, NY: Guilford Press
ISBN 1-57230-617-3

Helping Students Overcome Depression and Anxiety is a practical guide written for school counselors and other school-based mental health professionals as part of a larger series outlining various interventions to be used in school settings. It is a clear, well-written guide to intervention techniques designed to treat childhood depression and anxiety. It is an excellent starting point for clinicians interested in learning and implementing evidence-based techniques for the treatment of these disorders, particularly cognitive-behavioral techniques.

Dr. Merrell begins the book with two chapters that provide an overview of depression and anxiety. This overview includes information on the various disorders that fall under the classification of a mood or anxiety disorder, characteristics of these disorders, prevalence rates in children and adolescents, theories on how depression and anxiety develop and are maintained, and rates of comorbidity. In addition, he provides a brief discussion of other childhood disorders that have overlapping symptoms with depression and anxiety and gives tips on how to make an accurate differential diagnosis.

In the next chapter, Dr. Merrell provides detailed information on assessing depression and anxiety. He outlines a four-phase assessment process which includes: 1) clarification of who the client is and the purpose of the assessment, 2) data collection, 3) analysis of the data collected, and 4) identification of the most appropriate intervention based on the assessment data. The chapter outlines different types of assessment methods and there are tables detailing various behavior-rating scales and self-report measures. This information is very valuable and provides a quick reference for busy clinicians who want to learn more about possible assessment tools.

Next, Dr. Merrell outlines four comprehensive intervention programs for depression that have received empirical support: the Adolescent Coping with Depression Course, the Taking ACTION Program, Interpersonal Family Therapy for Depression, and Interpersonal Therapy for Depressed Adolescents. His review of these programs provides a general overview of the structure and techniques used in each of these interventions. Dr. Merrell identifies common elements of these treatments, and based on these common elements, he outlines a 10-session cognitive-behavioral intervention for depression that school clinicians can implement. Unfortunately, Dr. Merrell classifies all of these techniques as cognitive-behavioral. While there is clearly overlap among these various programs, they differ significantly in their theoretical orientation and some (Interpersonal Therapy for Depressed Adolescents) are not cognitive-behavioral treatments. Clinicians should familiarize themselves with the treatment programs and their supported research before initiating one of these programs. In addition, clinicians should be aware that there are other evidence-based treatments for depression that are not outlined in this book.

In the following chapters, Dr. Merrell outlines many of the cognitive and behavioral techniques that are used in these comprehensive programs. He breaks down the cognitive techniques into four steps: 1) developing awareness of emotional variability, 2) identifying one's patterns of thinking, 3) evaluating whether one's thoughts are realistic or helpful, and 4) changing negative thoughts that have been identified. Dr. Merrell describes a number of exercises that can be used in each of these steps. Next, he outlines behavioral interventions for depression including: 1) increasing the amount of time spent on positive activities,

2) reinforcing behaviors, 3) emotional education, 4) problem-solving, and 5) social skills training. Exercises are provided for each. The book provides useful guidelines on which techniques are appropriate for different aged children, and, at the back of the book there are worksheets that can be used to help implement these techniques. These worksheets are extremely valuable and can be adapted for individual students.

The section on treating anxiety disorders is not as comprehensive or as well organized as the section on depression. Despite this, the chapter on systematic desensitization is well-written and provides detailed information on relaxation training (including actual relaxation scripts), developing an anxiety hierarchy, and conducting exposure exercises. Dr. Merrell discourages clinicians from using in vivo exposure (in which you expose the child to the actual fear-inducing event or object, rather than have the child imagine it) because he feels that school environments are not conducive to this type of exposure. However, research indicates that in vivo exposure is often more successful than imaginal exposure. As such, in vivo exposure should be considered an important component of treatment for anxiety disorders.

The final chapter on anxiety disorders provides information on self-control training for anxiety, self-instructional training for anxiety, the Coping Cat program for anxiety, and the transfer of control approach. The summary of these treatments is brief, but provides a useful overview of the techniques used and provides information on how and where to learn more about the various treatment approaches. The chapter ends with a more detailed description of social skills training, which is frequently a component of cognitive-behavioral treatments for anxiety, although it is less successful as a stand-alone treatment.

The book ends with a useful discussion of when it may be necessary to refer the child for more intensive services and/or medication. In addition, Dr. Merrell provides information about commonly used medications to treat depression and anxiety in children and adolescents.

There is a debate among clinicians and researchers about whether it is sufficient to use a handful of cognitive-behavioral techniques as a supplement to your normal clinical work, or whether it is necessary to use a more comprehensive cognitive-behavioral treatment program to treat these disorders. Wherever you may stand on this debate, *Helping Students Overcome Depression and Anxiety* provides you with an introduction to both specific techniques and more comprehensive cognitive-behavioral treatments that can be used to treat depression and anxiety. In sum, this book is an excellent resource for school-based clinicians interested in learning new techniques, particularly cognitive-behavioral techniques, for treating depression and anxiety. It is easy to read and provides concrete, user-friendly tools that can be incorporated into one's clinical repertoire.

The author: Kenneth W. Merrell, Ph.D., is professor and director of the School of Psychology Program at the University of Oregon. Dr. Merrell has extensive clinical experience working with children and youth in school settings, and is a licensed psychologist and certified school psychologist.

The reviewer: Jami Finkelson, Ph.D., is a clinical psychologist and a Post-Doctoral Research Fellow at Columbia University. Her research focuses on the prevention and treatment of adolescent depression.

UPCOMING TOPICS

Resiliency

Resiliency refers to the ability of most youth to thrive despite adverse life circumstances. Volume 10(1) of *The Prevention Researcher* looks at the concept of resiliency and the differences between risk and protective factors. We will also examine how resiliency may be different for African-American youth and ways that service providers can incorporate resiliency into their work with youth.

Post-Traumatic Stress Disorder

How is post-traumatic stress disorder different for adolescents than adults? What are the signs and symptoms? How does it impact school work and general life functioning? Volume 10(2) will address these issues and many more as we delve into the topic of adolescent PTSD.

Other future topics include Teen Parents, The Effects of Domestic Violence on Teens, and Youth as Resources.

Grief & Bereavement Q&A

Ask Donna Schuurman, Ed.D., questions about adolescent grief & bereavement!

As a follow-up to our volume 9, issue 2 on adolescent grief & bereavement, we invite you to submit your questions about this topic to Donna Schuurman, Ed.D., executive director of the Dougy Center and author of the article "Teens & Grief."

The Q&A will be featured in our 2003 Resource Issue.

Log on to our website, **www.TPRonline.org**, and submit your questions today!

Athletes and Eating Disorders: An Interview With Dr. Randa Ryan

By Steven Ungerleider, Ph.D., Editor

Five years ago, Dr. Randa Ryan, Associate Athletic Director for Student Services at the University of Texas at Austin, wrote an article for *The Prevention Researcher* titled "Eating Problems in Athletic Settings." The topic of adolescent eating disorders has continued to be popular among our readers. We are delighted that Dr. Ryan agreed to the following interview.

Editor: Are there factors unique to sport which make eating disorders a special concern?

Dr. Ryan: Over the last decade there has been an increased concern about eating disorders, and some of that concern has been focused on sport. As it is difficult to collect empirical data on eating disorders due to their association with secrecy and denial, estimates are unclear and based primarily on incidences of self-report. Yet, contrary to some current misunderstandings, ***participation in sport does not cause eating disorders.*** Eating disorders are multifaceted and can have a variety of contributing factors. These factors can be physical, environmental, social, or psychological. If these factors exist in an athletic setting, eating disorders can increase, though it is a reflection of the predisposing factors and not sport.

As a result, athletes may be more susceptible to eating disorders for several reasons. In many sports, body weight can be a performance factor. Physiologically, excess weight may have a negative effect on performance. Therefore, athletes and coaches are often highly motivated to achieve optimum body weight. Yet, problems can arise with ascertaining what an athlete's optimal body weight is and its importance can be overemphasized. Also, there are environmental factors associated with sports that are different. Some athletes are susceptible to the amount of time they spend in workout clothing, focused on their body. They can be overly concerned and sensitive about how they look. Any inappropriate coaching or parental behavior associated with the sport environment can send powerful messages to athletes. Excessive demands for athletes to change their body can be misperceived and lower their self-esteem. Pressure to compete and fear of failure may create social and emotional isolation.

These are examples of factors that can increase eating disorders in an athletic environment, but, again, it is important to recognize that participation in sport does not cause eating disorders.

Editor: Are there particular sports which make eating disorders a special concern?

Dr. Ryan: Athletes in sports that emphasize low body weight, such as distance running, or sports that emphasize appearance, such as diving, can be at more risk. Therefore, it would be important for athletes, coaches, and parents involved in these sports to be especially aware of factors that may contribute to eating disorders.

Editor: Do eating disorders get worse when transitioning from high school to college?

Dr. Ryan: Times of transition can be associated with stress. Many athletes transitioning from high school to college sports speak about the difficulty and anxiety associated with their transition to the collegiate sport environment. Their sport becomes an even larger part of their lives and they are often unprepared for the large differences between high school and collegiate athletics. Additionally, new demands for higher standards, both academically and athletically, surprise many student-athletes. The greatest adjustment to these increased demands often occurs during the athlete's first year away from home. The pressures felt when juggling the roles of being an athlete and a student are greatly magnified in a new environment away from past support systems and successes. These factors can contribute to the start of an eating disorder or exacerbate an existing eating disorder.

Editor: What role do parents play in the risk of eating disorders?

Dr. Ryan: Parents, unaware of the power of their influence, may make demands that are unrealistic for their children. This can send strong messages that may be misperceived to an eating disorder-prone child. Parents should help their sons and daughters feel comfortable talking to them about their changing bodies, their sport training, and their relationships with their coaches and teammates. They should not make unrealistic demands on their children, especially in the areas of performance or body type. Parents must be aware of how much their words mean and never be overly critical about body size or shape. In addition, parents should be knowledgeable about the signs, symptoms, and contributing factors to eating disorders. Parents who are not well-informed can inadvertently be part of the problem. Both lack of knowledge and overzealous behavior can contribute to the manifestation of an eating disorder in a child.

Editor: What role do coaches play in the prevention of eating disorders and can they enable this behavior?

Dr. Ryan: Coaches can have the same power over young people as parents. Accordingly, they must understand the significance of their role and how an athlete may misperceive their comments or feedback. Coaches can enable an eating-disordered athlete by ignoring the behavior. Coaches often avoid the issue because it seems overwhelming, too complicated, or because an athlete is training well and they are hesitant to interfere with success. Coaches may also worry that they, in some way, have created or contributed to the problem; that their coaching style has pushed an athlete too far. It is critical for coaches to learn to distinguish the important variables that affect body weight as a performance factor and to identify athletes who might be prone to eating disorders. Coaches must also be responsible for educating themselves and for encouraging awareness in their athletes. Talking with athletes about eating disorders does not create or encourage the behavior and coaches must not avoid the topic.

Editor: There is so much importance put on weigh-ins. How can athletic directors or institutions change that?

Dr. Ryan: Body weight and its relationship to sport performance is considered by many to be a critical issue. Though research is limited in this area, most athletes and coaches conclude that lighter is faster and, therefore, better. Muscle tissue, which produces the force necessary for sport performance, is denser, takes up less space, and weighs more than fat tissue. A significant percentage of

an athlete's body is composed of muscle, and most athletes increase their muscle mass and decrease their fat mass in the process of becoming trained. They feel leaner and stronger, and their clothes are looser; yet the scale frequently reflects an increase in body weight. Though scientists are aware of what has happened, few athletes understand the difference between body weight and composition. Without access to the measurement of body composition, the use of body weight as measured by a scale to guide decisions about performance is precarious at best. A scale measures body mass and gravitational force, and gives no evaluation of conditioning levels, though it can be a critical tool for evaluating dehydration and fluid loss after physical activity. Two athletes of the same body weight can be at very different levels of conditioning and body composition. Even the same athlete can be in poorer shape at a lower weight simply because he or she has lost muscle mass. This concept forms the basis for what is wrong with the weighing-in process used by many coaches and athletes to make training decisions. In many cases, incorrect conclusions are drawn and, as a result, incorrect decisions are made.

In an attempt to change the weighing-in procedure and its related problems, 120 female athletes in seven sports at The University of Texas at Austin functioned under a different policy for one calendar year. The athletes had their body composition measured four to six times during the year by an expert, through the Sports Medicine Department. The coaches were given access to the data, though no coach was permitted to weigh-in the athletes, to set goal weights, or to interact with athletes in any manner about body composition or body weight. Athletes were given educational assistance in all relevant areas and access to professional support in areas such as nutrition and exercise physiology. At the end of the year, the athletes' mean body weight and body composition was compared to corresponding values from the previous year to examine the changes that may have occurred under the new policy. During the year when athletes were not being weighed-in by coaches or having coaches interact with them about their body composition or body weight, the athletes were leaner and more fit. In other words, their body composition values were lower. In addition, the incidence of eating disorders had decreased.

Removing the potential pressure imposed by coaches in the area of body weight, and also using an educational approach to help athletes understand the relationships between body weight, body composition and performance created a significantly healthier, happier, and more responsible group of athletes. Most athletes are very motivated to optimize their body composition and to do so in healthy ways. Providing education, and support, and empowering the athletes in a positive way helped them to be more successful and healthier in this area of their training.

Editor: If a peer suspects that a teammate is suffering from an eating disorder, what should he or she do?

Dr. Ryan: Given the opportunity, in a secure and non-threatening environment, athletes are usually honest in expressing how they feel about themselves and about their self-image and self-esteem as they relate to body weight, appearance, and weight as a performance factor. Therefore, it is crucial to create a mechanism for athletes to express how they feel about these issues. Athletes are very aware of team norms, behaviors, and perceived pressure by the group. Many times they know whether a team or a particular individual is in trouble. As a result, some of the most reliable and useful information can come from the athletes themselves. It is important that the fear of talking about eating disorders be removed and that athletes realize that eating disorders do not develop by talking about them or educating oneself about the risks. Fear also needs to be removed with respect to asking for help. Athletes should understand that they will never reach their full athletic potential if they are involved in this type of behavior because an eating disorder ultimately hinders performance. Encouraging a teammate or peer to get help or even, if necessary, informing the coach or a parent about a friend with an eating disorder, is the most important support a friend can give.

Editor: In your writing, Dr. Ryan, you have addressed barriers to the identification of an eating disorder among athletes, especially coaches who don't want to interfere. Is there a good and healthy way to intervene as a coach?

Dr. Ryan: Coaches should be aware, without being intrusive, of their athletes' eating and exercising patterns. Eating-disordered behavior should be taken seriously because of the seriousness of its consequences. Coaches must become educated and understand the disorders and their effects. The most important point of intervention for a coach to use is to approach the individual by addressing their feelings of loneliness, depression, withdrawal, isolation, low self-esteem, perfectionistic tendencies, or attempts to reach unrealistic expectations. By addressing the athlete's feelings, as opposed to behavior, coaches can assist their athletes in getting professional help from someone who is knowledgeable and experienced in the treatment of eating disorders.

Editor: Not much has been written about men and eating disorders. We have seen that 1/6 of the cases are male-related. Can you explain this phenomenon in men as opposed to women? Why has its prevalence increased?

Dr. Ryan: Eating disorders in male athletes have been largely under-reported, especially when the initial focus on eating disorders in sports began. It was primarily associated with wrestling, the main sport that has weight limits in male sports. Yet, over time, it became clearer that male divers and distance runners also report eating disorders. Male athletes report feeling pressure to increase body weight and muscle mass which can lead to abuses of steroids, supplements, high protein diets, and overtraining. But the pressure and importance of body image in general has increased dramatically for men as well as women and this may be why the reported incidences of eating disorders in men have increased.

Editor: Thank you Dr. Ryan for participating in this interview on this important topic.

Dr. Randa Ryan is an Associate Athletic Director for Student Services at the University of Texas at Austin. She and the Assistant Director for Sports Medicine, Tina Bonci, have worked together for almost twenty years on the Performance Team. The Performance Team is an interdisciplinary model which demonstrates how University academic expertise, intercollegiate athletics, and community professionals can be integrated within the higher education setting to protect the health and well-being, and enhance the performance of elite female athletes. For many years, a primary focus of this group has been the mental health needs of elite female athletes, eating disorders, body image, and body weight as a performance factor.

Steven Ungerleider, Ph.D., is a licensed psychologist and editor of *The Prevention Researcher*. He is the author of four books, most recently *Faust's Gold: Inside the East German Doping Machine* (St. Martin's Press, 2001), which was reviewed in *The New York Times*, *The New Yorker*, and on NPR (National Public Radio).

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Editorial Board

Our Editorial Board provides us with research advice and opinions throughout the year. Members donate their time to *The Prevention Researcher* in pursuit of our shared goal, to assist those who work with youth and ultimately, to assist youth. We would like to thank all of our Board members and take the time to highlight just a few of them, including their most recent accomplishments.

Myrna L. Armstrong, Ed.D., R.N., F.A.A.N., is a Professor at the School of Nursing at Texas Tech University Health Sciences Center, Lubbock, Texas, and a Colonel in the U.S. Army Reserves. She has conducted five studies and authored ten articles in peer-referred journals on body art with citations in *U.S. News & World Report* and *Reader's Digest*.

Recent publications by Dr. Armstrong include:

- Armstrong, M., and Frueh, S. (Eds.) (2002). *Telecommunications for Nurses: Providing Successful Distance Education and Telehealth*. Springer.
- Armstrong, M.L. and Kelly, L. (2001). Tattooing, body piercing, and branding are on the rise: Perspectives for School Nurses, *Journal of School Nursing*, 17(1), 12-20.

Also during 2000 and 2001, Dr. Armstrong and her research teams completed three major studies: One investigating college students with and without tattoos, another with college students with and without body piercing, and one national study exploring intimate body piercing (nipple and genitals).

Patricia J. Bush, Ph.D., is Professor Emerita at Georgetown University School of Medicine. Currently she is an Adjunct Professor, School of Pharmacy, University of North Carolina, Chapel Hill and Graduate Student Supervisor, University of Kuopio, Finland. As a consultant, she helped produce an interactive, multi-media, multi-award-winning CD-ROM for children with leukemia and their families (Kidz with Leukemia: A Space Adventure), and is currently helping produce one for adolescents with solid tumors. She also serves as senior consultant to a multi-center CERTs project on pediatric therapeutics based at the University of North Carolina, Chapel Hill, and is providing consultant services to an international project involving students in reducing inappropriate antibiotic use in their communities. Recent publications by Dr. Bush include:

- Dragone, M.A., Bush, P.J., Jones, J.K., & Kamani, S. (2002). Development and evaluation of an interactive CD-ROM for children with leukemia and their families. *Patient Education & Counseling*, 46(4), 299-307.
- Pradel, F.G., Hartzema, A.G., & Bush, P.J. (2001). Asthma self-management: The perspective of children. *Patient Education & Counseling*, 45(3), 211-24.
- Sleath, B. & Bush, P.J. (2002). Communicating with children about medicines. In W.N. Tindall, R.S. Beardsley, and C.L. Kimberlin (Eds.). *Communication Skills in Pharmacy Practice*, (4th ed). Baltimore, MD: Lippincott, Williams, and Wilkins.

Ruth Engs, Ph.D., is a Professor in the Department of Applied Health at Indiana University. She received her doctorate in Community Health Education from the University of Tennessee. Dr. Engs is the Editor of *Controversies in the Addiction Field* (1990), and *Women: Alcohol and Other Drugs* (1989), both published by Kendal-Hunt: Dubuque, Iowa. She is also the author of *Alcohol and Other Drugs: Self Responsibility* (1987) published by Tichenor Press and *Clean Living Movements: American Cycles of Health Reform* (2000) published by Praeger. Recently Dr. Engs was awarded the biennial, outstanding HPER Researcher Award for 2002.

Other recent accomplishments by Dr. Engs include:

- A reprint of her book *Clean Living Movements: American Cycles of Health Reform* in Fall 2001.
- Additionally, her new book, *Health Reform Movements of the Progressive Era: A Historical Dictionary* will be out in early 2003 from Greenwood Press.

Jacqueline M. Golding, Ph.D., is a psychologist in private practice and an Adjunct Professor at the Institute for Health & Aging, University of California, San Francisco. Dr. Golding's research interests include psychology of women, and relationships of stress to mental and physical health. She has published over 100 articles in scientific and professional journals. Dr. Golding was Principal Investigator of a five-year NIMH-funded study of the long-term physical health correlates of sexual assault history. Recent publications and presentations by Dr. Golding include:

- Golding, J.M. (2000). Longterm physical health problems associated with sexual assault history. *APSAC Advisor*, 13(1), 16-20.
- Golding, J.M., Taylor, D.L., Menard, L., & King, M.J. (2000). Prevalence of sexual abuse history in a sample of women seeking treatment for premenstrual syndrome. *Journal of Psychosomatic Obstetrics and Gynecology*, 21, 69-80.
- Golding, J.M., Wilsnack, S.C., & Cooper, M.L. (2002). Sexual assault history and social support: Six general population studies. *Journal of Traumatic Stress*, 15, 187-197.

Additionally, Dr. Golding was named a Fellow of the American Psychological Association effective January 1, 2002.

Richard Katzev, Ph.D., is President of Public Policy Research where he conducts research and consults on current social and environmental issues. Dr. Katzev received his Ph.D. in experimental psychology from Berkeley and taught at Reed College in Portland, Oregon until 1991. His current research emphasizes the importance of social behavioral models in addressing public policy issues.

Dr. Katzev's recent publications include:

- Katzev, R. (2002). *Comparing Recyclers and Nonrecyclers in N/NE Portland: Implications for Increasing Participation in the Curbside Program*. Final Report Submitted to the City of Portland Office of Sustainable Development.
- Katzev, R. (2001). *CarpoolMatchNW.org: Monitoring and Verification Plan*. Prepared for the Climate Trust.
- Katzev, R, Brook, D. & Nice, M. (2001). The effects of car sharing on travel behavior: Analysis during Car Sharing Portland's first year. *World Transport Policy & Practice*, 6(3), 22-28.

Glenn Meyer, Ph.D., is Chair of the Trinity University Psychology Department in San Antonio. Dr. Meyer's doctorate is from SUNY-Buffalo (1975) specializing in visual perception. Dr. Meyer is currently interested in visual perception and computer media in university and prevention education.

Recent publications and presentations by Dr. Meyer include:

- Lakin, C., & Meyer, G. (2002). *Perceptions of Lethality*. Annual Meeting of the Southwest Psychological Association, Corpus Christi, TX.
- Meyer, G. E. (2002). Colleges and gun violence. In G. Carter (Ed.), *Encyclopedia of Guns in American Society*. CA: ABC-CLIO.
- Meyer, G.E. (2001). Chair Session – Guns and Juveniles. Annual Meeting of the American Society of Criminology, Atlanta, GA.
- Meyer, G., & Lakin, C. (2002). Good guns, bad guns, gender and DGUs – Presidential Panel Session. Presented at the Annual Meeting of the American Society of Criminology, Chicago, IL.

We are pleased to welcome Randa Ryan, Ph.D., from the University of Texas at Austin, and Ronald J. Iannotti, Ph.D., from the National Institute of Child Health and Human Development, to our Editorial Board. Additionally, we would like to thank Marc Chafetz, J.D., for his contributions over the past 10 years.

Publications Available for Free

The following are reports and publications available for free on the Internet and, in some cases, by phone. Since Internet addresses may be case sensitive, we suggest you type them exactly as they appear here. While we strive to list reports only from reputable, stable organizations, Internet addresses seem to always be in a state of transition. These Internet addresses were correct when we went to press.

Alcohol

Alcohol Research and Health
(formerly Alcohol Health and Research World)
www.niaaa.nih.gov/publications/arh22-2/toc22-2.htm

Published 1998. Available in PDF format only. About 63 pages.

Alcohol Research and Health is a publication from the National Institute on Alcohol Abuse and Alcoholism. This 1998 issue focuses specifically on alcohol and youth. A sampling of article titles and authors includes "Alcohol Use Among Adolescents" by Patrick O'Malley, Lloyd Johnston, and Jerald Bachman, "Lessons From Project Northland: Preventing Alcohol Problems During Adolescence" by Carolyn L. Williams and Cheryl L. Perry, and "AOD Use and Attention Deficit/Hyperactivity Disorder" by Timothy E. Wilens. There are eight articles in all.

Community How To Guides on
Underage Drinking Prevention
www.nhtsa.dot.gov/people/injury/alcohol/
Community%20Guides%20HTML/Guides_index.html

Published March 2001. Available in HTML format only.

The Community How To Guides, developed by the National Highway Traffic Safety Administration, cover several important areas for communities wanting to implement underage drinking programs. These include coalition building, needs assessment and strategic planning, evaluation, enforcement, prevention, and education, as well as public policy advocacy and media relations.

Impaired Drinking Among Youth:
Trends and Tools for Prevention
www.health.org/govpubs/MS665

Published 1999. Available in HTML format only.

Published by the Center for Substance Abuse Prevention (CSAP) this online document gives brief overviews of strategies used to prevent impaired drinking and driving among youth. The highlighted strategies include minimum age purchase laws, zero tolerance laws, and graduated licensing.

Athlete's Substance Use

Anabolic Steroids: A Threat to Mind and Body
www.health.org/govpubs/phd561

Publication date unknown. Available online in HTML format only. Printed copies are available by calling 800-729-6686. (DHHS Publication No. (ADM) 91-1810).

This document provides a history of anabolic steroids, a glossary of terms concerning drug/steroid use in sport, and highlights health hazards for men, women, and adolescents.

TEAM UP: A Drug Prevention Manual for
High School Athletic Coaches
www.usdoj.gov/dea/demand/team-up.htm

Publication date unknown. Available in HTML format only.

This document is the result of a collaboration between the U.S. Drug Enforcement Agency and the National High School Athletics Coaches Association. It provides information, tips, and ideas specifically for high school athletic coaches.

Tobacco-Free Sports Playbook: Pitching Healthy Lifestyles to Youth, Teams, and Communities
www.cdc.gov/tobacco/sport_initiatives/CDC_Sports_Playbook.pdf

Published 2001. Available online in PDF format only. 98 pages. Also available for free by calling 1-800-232-1311.

According to the Center for Disease Control and Prevention Web site, this document is "designed to help coaches, school administrators, and state and local health departments reach out to young people with messages about the importance of choosing a healthy, active, and tobacco-free lifestyle."

Depression

Depression
www.nimh.nih.gov/publicat/depression.cfm

Printed 2000. Available in HTML and PDF formats. 23 pages.

Available from the National Institute of Medicine, this online publication includes basic information about depression, including the symptoms, causes and treatments. This publication covers depression among people of all age groups, not just adolescents.

Recognizing Depression in Youth
www.ohd.hr.state.or.us/ipe/depression

Published Summer 2000. Available in HTML and PDF format. 12 pages.

This report, while written to address Oregon's suicide problem, is a depression resource for youth-serving professionals regardless of the state they live in. Unique aspects of this document includes an extensive list of symptoms to help identify depression among youth, and a discussion of the impact of adolescent depression in our educational and legal systems.

"The Prevention of Depressive Symptoms in Low-Income Minority Middle School Students" and "Preventing Depressive Symptoms in Chinese Children"
journals.apa.org/prevention

Published May 2002. Available in HTML format only.

The American Psychological Association publishes the online journal, *Prevention and Treatment*, which is currently available to the public. Both of these articles on preventing depression among children are available along with comments from other researchers.

Dropouts

Dropout Rates in the United States: 2000
nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2002114

Published November 2001. Available in hard copy (order form on the site) and PDF format. 95 pages.

This report, from the U.S. Department of Education, is the 13th in a series of reports which have examined high school dropout and completion rates since 1972. It presents the data from 2000, which is the latest year available.

Subsequent Educational Attainment of High School Dropouts
nces.ed.gov/pubs98/98085.html

Published June 1998. Available in PDF format only. 80 pages.

By the U.S. Department of Education, this report uses the National Education Longitudinal Study to examine the fates of 1,988 eighth graders who reported dropping out of high school in the 1988 study. Six years later, 45% received either a high school diploma or GED.

Eating Disorders

Eating Disorders: Facts About Eating Disorders and the Search for Solutions
www.nimh.nih.gov/publicat/eatingdisorder.cfm

Printed 2001, updated June 2002. Available in HTML and PDF formats. 12 pages.

This online publication by the National Institute of Mental Health was written for the public. It includes basic information about anorexia, bulimia, and binge eating, as well as information on treatment and the latest research.

Eating Disorders During Adolescence: Nutritional Problems and Interventions
faculty.washington.edu/jrees/adolescentnutrition.html

Revised May 2002. Available in HTML format only.

Written by a faculty member in the School of Public Health and Community Medicine at the University of Washington, this online book has also been reviewed by a pediatrician, a nutritionist, and a psychologist. The goal of this Web site is to be a "reference for health care professionals, students and educators." Covered are the topics of prevalence and consequences of disordered eating in adolescents, and detailed information about anorexia nervosa and bulimia.

Taking it to the Mat: The Wrestler's Guide to Optimal Performance
www.ncaa.org/champadmin/wrestling/mat.pdf

Publication date unknown. Available in PDF format only. 20 pages.

Written for the NCAA by The Center for Nutrition in Sport and Human Performance, this publication is specifically for wrestlers. It highlights dangerous weight-cutting methods and gives alternatives.

Hispanic Students

Developing Effective Messages and Materials for Hispanic/Latino Audiences
www.health.org/govpubs/MS703

Published 1997. Available in HTML format only.

This document, published by the U.S. Department of Health and Human Services, discusses the six-stage health communication process and how to draw on community-based values and traditions to promote that message.

Key Indicators of Hispanic Student Achievement
www.ed.gov/pubs/hispanicindicators

Last updated 2000. Available in HTML and PDF formats. 8 pages.

Produced by the Department of Education, this report defines the national goals for improving Hispanic students' educational achievement. It also includes indicators of the progress that has been, or needs to be, made.

Review of the Literature on Hispanic/Latino Parent Involvement in K-12 Education
www.buildassets.org/products/latinoparentreport/latinoparentrept.htm

Published 2002. Available in HTML and PDF formats. 20 pages.

Published by Assets for Colorado Youth, this report highlights the barriers which keep Hispanic/Latino parents from being involved in their children's education, and what has been successful in increasing participation.

School Practices to Promote the Achievement of Hispanic Students
ericcass.uncg.edu/virtuallib/diversity/1072.html

Published March 2000. Available in HTML format only.

This short report from the ERIC Clearinghouse on Urban Education summarizes the recommendations from the "Transforming Education for Hispanic Youth: Exemplary Practices, Programs, and Schools" report, complete with brief examples from the case studies.

Transforming Education for Hispanic Youth: Exemplary Practices, Programs, and Schools
www.ncela.gwu.edu/ncbepubs/resource/hispanicyouth/hdp.htm

Published 1999. Available in HTML and PDF formats. 114 pages.

Published by The National Clearinghouse for Bilingual Education, this document presents several case studies from the Hispanic Dropout Project which exemplify the recommendations which emerged from that project.

Homeless Youth

Homeless Adolescents In The United States: An Overview for Pediatricians
www.int-pediatrics.org/newip/volumes/volume%2017/17-2/review/greydanus/homeless.htm

Published 2002. Available in HTML and PDF formats. 5 pages.

This full length article from the online journal International Pediatrics, covers such topics as the health concerns of homeless youth, psychosocial health risks, and the provision of health care.

Homeless Children: Addressing the Challenge in Rural Schools
www.ael.org/eric/digests/edorc981.htm

Published 1998. Available in HTML format only.

Part of the ERIC Clearinghouse on Rural Education and Small Schools, this article was written by Dr. Yvonne Vissing, an author for *The Prevention Researcher*. This digest takes a look at the special challenges, causes, and needs of rural homeless youth and schools.

Lesbian, Gay, Bisexual, and Transgender Youth

A Providers Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals
www.health.org/govpubs/BKD392/index.pdf

Printed 2001. Available in PDF format only. 209 pages.

Published by the Center for Substance Abuse Treatment, which is part of the federal Department of Health and Human Services, this document is the work of clinicians, researchers, program and administrative managers, policy makers, and others, who came together to review and discuss the current practices for treating substance-abusing lesbian, gay, bisexual, and transgender (LGBT) individuals. This document highlights the problem of substance abuse among this population, cultural issues when working with LGBT clients, the effects of homophobia and heterosexism on LGBT persons, families of origin and families of choice, myths and stereotypes, and more.

Technical Assistance Sampler on Sexual Minority Students
smhp.psych.ucla.edu/pdfdocs/sexual_minority/lgbt.pdf

Published 2000. Available in PDF format only. 89 pages.

By the School Mental Health Project at UCLA, this document highlights the issues facing sexual minority students and staff, and interventions for assisting sexual minority students. It includes excerpts from other documents produced by the National Association of School Psychologists, the National Dropout Prevention Center/Network, and the U.S. Department of Education.

A Mental Health Response to September 11

On September 11, 2002, the first anniversary of the horrific tragedy that shook the U.S., Dr. Steven Ungerleider, editor of *The Prevention Researcher*, thought it was important to ask our mental health community some questions. He wanted to get a first hand read on what his colleagues were doing, thinking, feeling, acting.

Many psychologists from around the country were pulled into action by the Red Cross disaster relief team, the same team that recruited professionals during the 1995 Oklahoma City bombing, but this was a bit different. "I knew that many responded but I didn't know the scope and depth of this response," Dr. Ungerleider said. He learned that hundreds of psychologists went to New York on a moment's notice, pro bono, leaving their families and their active careers on hold. Five Oregon psychologists traveled some 3,300 miles to "ground zero." Following is an interview with one of those psychologists, Dr. Terrie Lyons, from Portland, Oregon.

Dr. Ungerleider: Why did you decide to go to New York to assist the victims of September 11? How did it all happen?

Dr. Lyons: I had experience with trauma and working with patients who had been assaulted, or sexually and physically abused. I understood PTSD [post-traumatic stress disorder]. I was experienced as a Red Cross responder and I felt it was important to be a mental health caregiver for this terrible crisis in New York.

Dr. Ungerleider: What was the process to get you there?

Dr. Lyons: I made contact with the Red Cross in September and they checked my credentials and my background to make sure I was legitimate. I had to have a medical checkup and then I was notified that I had been selected. It was last minute—there was no advance notice—they told me to show up in New York the week before Thanksgiving. I notified my patients in Portland, where I have a private practice, that I would be gone for 10 days and flew to New York.

Dr. Ungerleider: What was the next step in the process of working with the victims?

Dr. Lyons: It was a bit chaotic at first; all mental health professionals (from across the country) were processed in Brooklyn. They checked our backgrounds, credentials, criminal records, medical forms, all of the relevant data to make sure we were real mental health folks. We were then interviewed in person, given an orientation of the city, and sent over to Pier 94 (a large structure on the West side near downtown) where the triage center was organized.

Dr. Ungerleider: What was your first impression of the crisis center?

Dr. Lyons: There was some initial confusion. There were the federal government folks and then the New York City mental health coordinators. There were two distinct areas separated; the FEMA group worked on one side, the New York group worked on the other. I was assigned to families of victims, and it was awkward at first.

Dr. Ungerleider: How did your first day go at the trauma center?

Dr. Lyons: It was very emotional! There was the "Walk of Bears" room. This was an area full of adorable teddy bears next to photographs of lost workers and victims where survivors and their families could come in and try and find their loved ones. The bears were gifts from victims of the Oklahoma City bombing who sent thousands of bears to support the people of New York.

Dr. Ungerleider: What happened with your grief and trauma counseling? How did it begin?

Dr. Lyons: We were asked by the New York City officials and the Red Cross to meet with families of the victims as they entered the building and started to search and ask questions. Some were very disoriented and confused. Some came in terribly angry and just wanted immediate answers. There was a whole spectrum of needs and emotions. I tried to just sit and listen to victims as they talked about their loved ones.

Dr. Ungerleider: What was the procedure for finding people and getting closure?

Dr. Lyons: Unlike a rape or car crash, there was no immediate closure to the grief. Bodies were not found for most families, so there was a lot of unfinished business. We were given beautiful mahogany urns placed in velvet bags that the city of New York had created. They were to house the ashes from the two towers. The urns were presented with an American flag to any family that was ready to receive them. This was the first stage of closure and the beginning of the grief process. Many families refused at first and would come back to Pier 94 several times before they asked for an urn with ashes and a flag that would symbolize the death of their loved one. It was very painful to witness this process.

Dr. Ungerleider: How did this affect you? What images came up for you during this process?

Dr. Lyons: Two things emerged. The power of the American flag, its colors, its stars and stripes, the significance of our national flag, it really overwhelmed me. Second, I reflected on my father and his father, my grandfather. Both had been military men and both had special funerals where a flag was presented. My dad, who was a physician, was very involved in the community. He gave a lot of his time and professional expertise. And it all came flooding back, that I was here in New York, perhaps carrying on the family tradition of giving something back.

Dr. Ungerleider: What about your work as a psychologist, a mental health professional?

Dr. Lyons: I think by going to New York, preparing for the trip, leaving my home, the safety and security of my little world, gave my work and my mental health background a sense of relevance. It made my work as a therapist more powerful and present. I understood in a different way the process of denial, anger, letting go, a new understanding of the grief process.

Dr. Ungerleider: Did your trip have other relevance to your life, both professional and personal?

Dr. Lyons: Indeed, there were days when I was not sure why I went to New York. And then there were days when I met with a family and I really felt I had an impact, I had a true sense that I was a catalyst in their healing process. It was very powerful and significant.

Dr. Ungerleider: What are your thoughts and predictions for the future, for PTSD and youngsters who will be living and reliving the trauma of September 11 images for many years?

Dr. Lyons: No doubt we will see a new wave of PTSD, perhaps a new shape of trauma. I worked with children who lost parents and siblings, who are having flashbacks, insomnia, problems with school and everyday adjustment. So no doubt we will see this stress manifest in long-term illness and perhaps other areas where coping strategies fall down. Clearly, kids from dysfunctional families and those on the edge will have more severe reactions

to each anniversary of September 11. However, I also believe, and I saw this first hand, that we will have children and families make positive changes in their lives. We have seen families become more spiritual, reassess the true meaning of their daily lives, and rethink positive decision making. So, I believe, that September 11 and the aftermath of this tragedy may manifest itself in many ways along the spectrum.

Dr. Ungerleider: How did your colleagues and your patients respond when you returned home?

Dr. Lyons: I felt very supported by both groups. The state psychological society held a symposium for the five psychologists who went, to talk about our experience. This was an incredible education; an enlightening and supportive experience for all of us. My patients asked many questions and were very supportive of my work and offered me incredible validation for going. In many ways, my patients felt that they were part of this healing as they talked about it in our sessions. In return, I felt I could give more to them, I could be closer to them and connect with them in a more present and clear path. It was an interesting phenomenon, a give and take, something that has changed my life.

Dr. Ungerleider: Terrie Lyons, I thank you for sharing this important experience. I commend you for your courageous gift in helping the victims of September 11.

Terrie Lyons received her M.S.W. from UC Berkeley in 1975 and her Ph.D. in psychology at the Wright Institute in Berkeley in 1986. Dr. Lyons worked as a clinical supervisor at Providence Hospital in Portland for a number of years before starting a full-time private practice in 1991. She has been involved with the Red Cross as a Disaster Action Team member since 1996. In this role, she has been called out on numerous fires and floods.

Steven Ungerleider, Ph.D., editor of *The Prevention Researcher*, is a licensed psychologist and director of Integrated Research Services, Inc. He is a member of the United States Olympic Committee and a published author. His latest book, *Faust's Gold: Inside the East German Doping Machine* (St. Martins Press), chronicles the victimization of East German athletes who were unknowingly injected with dangerous and illegal drugs for over 30 years.

BOOK REVIEW

Adolescents, Alcohol, and Substance Abuse: Reaching Teens Through Brief Interventions

By Peter M. Monti, Suzanne M. Colby, and Tracy A. O'Leary, Editors
Reviewed by John de Miranda, Ed.M.

2001. New York, NY: Guilford Press
ISBN 1-57230-658-0

The development of alcohol and drug treatment services for adolescents in the U.S. has lagged far behind the evolving service system for adults. At the same time, adult treatment approaches characterized by the 12-step and abstinence-oriented treatment models have limited utility for young people struggling with problematic substance use or engaging in experimentation.

Compounding these problems are conflicting politics and ideological concepts that bedevil discussions about the appropriate societal response to youthful alcohol and drug use/abuse. For example, for some time drug experimentation has been normalized among adolescents. It is seen as an acceptable behavior among high school and college students despite the exhortations of parents and drug prevention programs such as D.A.R.E. As the father of a teen, I often marvel at our society's ambivalence about youthful alcohol and drug use.

Speaking recently to educators in Brisbane, Australia, Rod Skager, Professor Emeritus at the Graduate School of Education and Information Studies, University of California, Los Angeles said:

> "Exaggerating dangers and demonizing behaviors that are engaged in by large numbers of youth and adults is a dangerous business. The U.S. experience has been that increasing public fears about drugs yields enhanced funding for ineffective interventions and more punitive law enforcement. For example, the California legislature is currently considering a law that would criminalize smoking by teenagers."

Within such a difficult environment we can only welcome the contribution of three scholars at the Brown University Center for Alcohol and Addiction Studies who have authored an important supplement to our understanding of alcohol and drug problems in adolescents. The volume, *Adolescents, Alcohol, and Substance Abuse: Reaching Teens Through Brief Intervention* edited by Peter Monti, Suzanne Colby, and Tracy O'Leary should become a standard desk reference for any practitioner, researcher, or program developer involved in substance abuse services for teens. Particularly impressive are the hundreds of scholarly references that will help the reader delve more deeply into particular areas of interest.

The volume grew out of a multidisciplinary conference convened in 1998 and supported by The Robert Wood Johnson Foundation. Chapters emerged from commissioned manuscripts as well as from knowledge gaps that were identified during and after the conference. The result is a compendium of eleven articles divided into three sections.

Part I, "Background and Context: Theory, Developmental, and Measurement Considerations," explores the basic premise of the book that "substance abuse and dependence in teens is different from that in adults." A section by John Schulenberg

explores developmental transitions during adolescence and five conceptual models useful in explaining how substance abuse problems emerge in young people. Also included is a discussion of risk and protective factors and the intervention implications of the developmental perspective.

A chapter on harm reduction from Elizabeth Miller, Aaron Turner, and Alan Marlatt provides a thoughtful discussion of the value of this strategy, imported from Europe in the 1990s. Despite the refusal of federal and state policymakers to legitimize this modality to help young people already engaged in drug and alcohol use, more and more clinicians and youth workers are adopting harm reduction approaches that include heroin overdose prevention and testing drugs for adulterants at raves. Also presented in this chapter is a summary of some of the harm reduction-based, brief intervention studies that have proven effective in reducing problem substance use in college students.

Part I also includes a section on assessment that comprehensively reviews assessment instruments and suggests future research directions. The final chapter in Part I includes a discussion of personality-based risk models and psychological expectancy theory.

Part II provides the practitioner with a wealth of practical information, including transcriptions of actual interactions with adolescent clients. Both motivational enhancement strategies and brief interventions that focus on alcohol consumption and risky behavior are developed in this section. The goal is to "promote interest in making positive changes to hazardous drinking patterns."

A chapter on alcohol skills training for college students provides step-by-step instruction in the use of an approach that acknowledges that college students drink and encourages behavior that reduces risk. The strategy "acknowledges that episodic heavy drinking in this population is generally normative and transitional and views college years as a window of risk through which students must pass."

For the clinician there is a chapter on integrative behavioral and family therapy by Holly Barrett Waldron, Janet L. Brody, and Natasha Slesnick. The chapter provides an overview of the theoretical underpinnings, describes the core components of interventions and the empirical evidence for this approach. Because early sexual initiation and substance use are closely linked, another chapter discusses motivational interviewing and the prevention of HIV infection. Again, this presentation is helpfully illustrated with case studies of interviews and role plays with teenagers in primary care. Another chapter is included on brief interventions for adolescents with substance abuse and co-morbid psychiatric problems with specific recommendations for different settings including inpatient, outpatient, primary care, juvenile justice, and school-based venues.

Part II ends with a useful chapter on how the Internet can engage teens in substance abuse prevention and treatment. It presents examples of "how information can be presented in a non-judgmental, fun environment through quizzes, simulations, fact sheets, self-assessments, personalized feedback, and peer discussion groups." Also discussed is the importance of engaging young people directly in health promotion activities and treating teens as stakeholders, not simply as service recipients.

Part III discusses future directions and the need for more cross-disciplinary research to improve brief interventions, the ultimate goal of which is the "integration of basic science and its applications to intervention and policy formation, within a life-span developmental perspective and across the bio-behavioral and nested contextual environmental domains, provides a template for the next decade to guide research that will inform practice and benefit society."

As a policy maker and instructor in an alcohol and drug studies department, I found this book to be an authoritative short course in current research and practice concerning adolescent development, brief intervention theory/practice, and substance abuse prevention and treatment. As the father of a 13-year-old, I also found it to be helpful in improving my understanding the hows, whys and what ifs of teen alcohol and drug use/abuse. -AP

The editors: Peter M. Monti, Ph.D., is professor of Medical Science and the Director of the Center for Alcohol and Addiction Studies and the Clinical Psychology Training Consortium at Brown University. Suzanne M. Colby, Ph.D., is assistant professor in Psychiatry and Human Behavior at Brown University. Tracy A. O'Leary, Ph.D., is assistant professor in the Department of Psychiatry and Human Behavior at Brown University.

The reviewer: John de Miranda, Ed.M., is the Executive Director of the National Association on Alcohol, Drugs and Disability and is the Coordinator of the California Prevention Congress. With a professional background in the alcohol and drug problems field that spans 19 years, Mr. de Miranda has served as program administrator, management consultant, therapist, educator, government official, researcher, and trainer. As the son of a Cuban immigrant, he earned a Master's degree in Counseling & Consulting Psychology from Harvard University in 1979.

Drugs and Sports

By Rodney G. Peck

Reviewed by Ray Tricker, Ph.D.

Revised edition 1997. The Rosen Publishing Group, Inc.
ISBN 0-8239-2565-x

Drugs and Sports is the second edition of a book originally published in 1992. The author, Rodney Peck, states in the introduction to this book that millions of high school students in the United States are involved at different levels in a variety of organized sports such as soccer, football, track and field, tennis, swimming, wrestling, baseball, softball, and many other physical activities. This book is designed to target students who are in the high school age group. The writing style throughout the book is informal, and the book attempts to "speak" to the reader (the high school student athlete) through personalized, interpretative statements and explanations.

The important issue of drug use in sports is very relevant to this age group because the competitive intensity in sports at the high school level is high and many students, coaches, parents, and team members are continuously looking for new and more effective ways of gaining an advantage over their opponents. *Drugs and Sports* addresses a topic that can have far-reaching affects on this population. There are many issues and risk factors that may lead to the abuse of drugs and performance enhancing aids. The introduction to the book is promising, and is followed by five chapters that address drugs and their effects on the body, anabolic steroids, athletes who chose or did not choose to use drugs, and aiming to be the best.

The discussion related to the effects on the body briefly refers to harmful drugs, discusses addiction and experimentation, interspersing a presumably fictitious account of a student who became a habitual marijuana user. With the exception of reference to a "student-athlete," this chapter does not explain how marijuana or any other of the harmful drugs affect performance, or how any drugs may affect performance. A dominant message from this chapter seems to be that student-athletes who use drugs will become addicts.

Chapter two addresses issues related to anabolic steroid (AS) use, with very basic information about the relationship of AS with testosterone, the sports in which AS use is most prevalent, and the side effects of steroid use in males and females. The middle of this chapter provides a somewhat distracting and not directly relevant fact sheet about alcohol, tobacco, marijuana, cocaine, and steroids that does not relate these substances to their effects on athletic performance. The end of this chapter switches sharply from accounts of athletes who used steroids to the "black market" and the cost of AS. Anabolic steroids are certainly one of the important groups of performance-enhancing aids, but other aids such as erythropoietin, different forms of stimulants, prescription medications, androstenedione, DHEA, GHB, food supplementation, and many other important substances are omitted from discussion.

Chapter three reverts back from the performance-enhancing drug of choice to behavioral issues, and why athletes begin using drugs. Short sections in this chapter deal with peer pressure, using drugs to be cool, and using drugs to "look good." The chapter touches on the issues without providing any challenging or thought-provoking insights into why athletes use drugs. The discussion moves quickly and somewhat abruptly from topic to topic, without providing connecting threads between them. The chapter ends with a brief overview of collegiate athletics, and an even shorter coverage of professional sports.

Chapter four provides examples of some professional and Olympic athletes who used drugs, and the consequences following use, with evidence of the loss of opportunities, financial losses, and personal losses.

The final chapter focuses on a positive note and provides examples of celebrated athletes who achieved outstanding results. Some reference is made to the importance of mental and physical discipline, but no helpful indicators reveal how these important qualities are developed; however, much more direct guidelines are provided in relation to what a young high school athlete should look for in a potential teammate who is abusing an illegal substance.

The fact sheet at the end of the book provides general national statistics and information about negative outcomes related to drug use in the United States. From 22 different facts only five relate to potential performance enhancing aids; four relate to steroids, and one to amphetamines. The reference sources for the facts on the fact sheet are not disclosed. The glossary provides basic definitions for some of the terms used in the book. Some nationally known hot lines, and suggestion for further reading are also provided, most of which are unrelated to drugs and sports. There are a number of well-written books on the topic of drugs in sport that could be included in the list; for example, *Drugs and the Athlete*, by Gary Wadler and Brian Hainline, and *Drugs in Sport*, by D.R. Mottram.

The title of this attractively printed book, *Drugs in Sports*, directs attention toward a very important topic that interests millions of high school student athletes. The content, style, and reading age of the text perhaps seems appropriate as a quick reference text for freshmen high school students with limited reading ability; however, information contained in this short 64-page book is not sufficiently challenging to interest many upper level high school students. Much of the content is connected to the issues of drug abuse in general and could equally apply to any high school student. The book frequently missed opportunities to more directly address issues related to drug abuse and sports. -ar

The author: Rodney G. Peck graduated from Central Michigan University. While there, he became involved with the America's PRIDE program which uses alternatives such as dancing, singing, and acting as ways to combat drug use. He has spoken to thousands of young people on the topics of peer pressure, self-esteem, and drug use. He is currently a Peace Corp Volunteer, working in drug education in Belize.

The reviewer: Dr. Ray Tricker is an Associate Professor of Public Health at Oregon State University. He has conducted extensive research, and developed drug education materials for the NCAA, and has published widely in the prevention and intervention literature on health behavior and drug education.

Subject Index

This cumulative topic index reflects the past nine years of The Prevention Researcher. *This will assist you in finding articles in our back issues. Additionally, several of these articles are available on our Web site. Back issues can be ordered on the web (at www.TPRonline.org) or by calling 800-929-2955 ext. 19. This index has one or more entries for each item published. The name of the first author is in brackets following each article title.*

African-American Youth

African-American Adolescents' Responses to Perceived Gun Carrying by School Mates [Martin], 1999, Vol. 6(2), pp. 1-3.

Coming of Age Ethnically: Teaching Young Adolescents of Color [Gay], 1998, Vol. 5(1), pp. 7-9.

Alcohol Use (see also, Substance Use)

A Brief Alcohol Preventive Intervention for Student Athletes [Werch], 2002, Vol. 9(3), pp. 4-5.

Alcohol Use Among Adolescents [Windle], 2002, Vol. 9(3), pp. 1, 3.

Alcohol Use Among High School Athletes [Carr], 1996, Vol. 3(2), pp. 1-3.

Community Action to Reduce High School Adolescent Alcohol Use [Perry], 2002, Vol. 9(3), pp. 12-16.

Family, Religious, School and Peer Influences on Adolescent Alcohol Use [Mason], 2002, Vol. 9(3), pp. 6-7.

Preventing Underage Alcohol Access: Policy and Enforcement [Stewart], 2002, Vol. 9(3), pp. 8-11.

Project Northland: Outcomes of a Community-Wide Adolescent Alcohol Use Prevention Trial [Perry], 1998, Vol. 5(2), pp. 8-12.

Asian-American Youth

Coming of Age Ethnically: Teaching Young Adolescents of Color [Gay], 1998, Vol. 5(1), pp. 7-9.

Athletes, High School

A Brief Alcohol Preventive Intervention for Student Athletes [Werch], 2002, Vol. 9(3), pp. 4-5.

Alcohol Use Among High School Athletes [Carr], 1996, Vol. 3(2), pp. 1-3.

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